Socially withdrawn young people: how do child and adolescent psychotherapists understand and experience working with them in a London mental health context? An interpretative phenomenological analysis.

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Contents

Abstract

This research project aimed at learning more about adolescents and young adults who withdraw into their rooms away from society, in the eyes of the child and adolescent psychotherapists who work with them. The study explored this concept, first identified in Japan as 'hikikomori' (shutting in), in a UK context, where it is rapidly growing, particularly in the aftermath of the Covid-19 pandemic, and it is increasingly coming to the attention of mental health services. The aim of the project was to investigate child and adolescent psychotherapists' understanding and lived experiences of working with withdrawn young people in order to begin to contribute to a knowledgebase around this topic that can hopefully, with further research, have implications for future clinical services in Great Britain.

The study incorporates firstly a review of the literature and secondly an empirical project that took place in two London-based mental health settings in the form of four semi-structured interviews with Child and Adolescent Psychotherapists who had clinical experience of working with withdrawn young people.

The interviews were analysed using Interpretative Phenomenological Analysis and five main themes emerged: 'the who and the what', 'contributing factors', 'a retreat from life', 'an entrenched problem', and 'the road to recovery'. These themes and their subthemes were explored in relation to empirical studies in the literature and psychoanalytic theories on 'psychic retreats' and on adolescence. The implications of the findings were considered and recommendations made.

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Introduction

This research project aims to explore how a small group of child and adolescent psychotherapists in two London mental health services understood and experienced working with socially withdrawn adolescents and young adults. There is extensive research on different forms and variations of social withdrawal and its correlation to other conditions, including developmental delays, speech problems and personality traits (Barzeva et al., 2019). However, specific research on the subject of youth acute social withdrawal – people shutting themselves in their homes or bedrooms and having very limited social contact with others – has been found in relation to the 'Hikikomori' syndrome that was first reported in Japan. This area will be the focus of this research study.

Context

'Hikikomori' (translated as 'pulling inwards') is a growing phenomenon first discovered in Japan by psychologist Saito (Tamaki & Angles, 2013). In the last two decades, it has been studied in the Japanese culture and society (Pozza et al., 2019), where the hikikomori phenomenon has been rapidly growing (Nonaka et al., 2019). A study on the epidemiology of hikikomori in a community-based population aged 20–49 years in Japan showed that 1.2% had experienced the phenomenon in their lifetime (Koyama et al., 2010).

It refers to a period of severe social withdrawal from society lasting six months or longer and that mainly affects adolescents and young adults, who spend the majority of their time in their rooms, reject most social contact, and often refuse to go to school or work TEO. This

condition also typically affects males with a 4:1 male-to-female ratio (Pozza et al., 2019) and Saito (Tamaki & Angles, 2013) found that that 70% to 80% of Hikikomori are men.

According to Bowker (2019), the fact that it has been argued that hikikomori is a culture-bound syndrome, unique to Japanese society with culture-specific causes, may explain why relatively few authors have researched the experience of hikikomori outside of Japan. However, several studies have reported the prevalence of individuals with hikikomori in other countries outside Japan in recent years (Kato et al., 2012; Teo et al., 2015) TEOadd. Indeed, research has so far found that the estimated prevalence of this phenomenon in the general population worldwide is 1.5%, which rises in male and younger individual, and may vary from 12.64% up to 63.07% in clinical populations (Pozza et al., 2019). An audit in a highly relevant study conducted in a UK London-based mental health service (Mohr, 2021), shows that of 167 referrals within a six-month period, 16% met the Hikikomori definition, and a further 13% were at risk of such severe withdrawal, which are high numbers for a condition not yet defined in the UK.

International debates on the psychological and social factors involved have emerged and some studies are also pointing at the risks linked to this syndrome. A recent large-scale empirical study covering 11 European countries, for example, has found that youth who have high media use (i.e., Internet, TV, and videogames use for reasons not related to school or work), engage in more sedentary behaviour, and experience reduced sleep, represent “invisible” risks (Carli et al., 2014). Findings show that young people in the invisible risk group had a similar prevalence of suicidal thoughts, anxiety and depression compared with the high-risk group. The study suggests the importance of this becoming a new intervention

target group to reduce these high-risk behaviours in young people who may not be seen as high risk.

Moreover, as adolescence is such a crucial time for the development of interpersonal relationships, withdrawing during this period may lead to the risk of future problems, such as becoming 'NEET', thus not in education, employment or training (Bowker et al., 2019; Carli et al., 2014), or a 'Parasite Single'/'Twixter', therefore staying with parents far into adulthood (Lee et al., 2013; Yong & Nomura, 2019).

Finally, some studies also point at the risks linked to the potential consequences of the pandemic on vulnerable young people globally (Rooksby et al., 2020).

Rationale for my research study

This study was designed in order to address three main important areas:

1. As highlighted above, studies have shown that the phenomenon of Hikikomori is growing and expanding globally. Increased media use and the evolution of communication from direct to progressively indirect and physically isolating, where contact takes place in a virtual space rather than a mutual physical one (Kato et al., 2018), are major leading factors in Hikikomori being more global and rapidly increasing. Moreover, the negative impact of the COVID-19 pandemic on young people has been researched extensively (Branje & Morris, 2021; Kiss et al., 2022; Li et al., 2022; Spettigue et al., 2021; van Loon et al., 2021) and the number of school-refusing children has been growing since the periods of lockdowns and social

restrictions. Therefore, this could be a serious contemporary phenomenon affecting a substantial number of young people and thus requires further attention.

2. A scoping review of the literature reveals that qualitative research about the experiences of acute social withdrawal seems to be particularly limited. Exceptions in Western contexts include an analysis of direct narratives of affected young people (Caputo, 2020); a doctoral thesis on relationship dynamics of withdrawn adolescents and young adults (Mohr, 2021); and another doctoral research exploring young people's past experiences of social withdrawal (McCullagh, 2020). This lack spurred me on to design and carry out my doctorate research in this field in order to investigate aspects of this phenomenon that are lacking and needed to foster greater understanding, especially in a UK context.

3. Moreover, there is a lack of specific research on clinicians' views and experiences of working directly with families and young people affected by this syndrome. The exception in the UK is Mohr's (2021) important doctoral thesis on therapists' reflections about their withdrawn adolescents in a clinical setting. Mental health professionals are the ones that are most likely to have to increasingly work with this phenomenon, therefore their experiences at present constitute a valuable starting point for achieving more understanding. This has implication for future treatment interventions in London mental health services when facing a version of this issue in a UK context. I have chosen London as the location for my research because it is the city where I live, train and work. Additionally, the fact that it is a large metropolitan city makes it a good starting point for this exploratory project.

Definitions

The term ‘Hikikomori’ derives from Japanese, and it is composed of the verb ‘hiki (hiku)’, which means to move back, and ‘komori (komoru)’, which means to come into. It therefore means ‘shutting in’ and it is typically referred to as ‘social withdrawal’ in English (Caputo, 2020; Pozza et al., 2019). Although this phenomenon still requires a more coherent and formal conceptualisation globally as my literature review highlights, and different degrees have been identified, with ‘hard core’ and ‘soft’ subtypes indicating to what extent contact with others is severed (Pozza et al., 2019), the terms ‘hikikomori’ and ‘social withdrawal’ will be used interchangeably throughout this thesis. Indeed, as I intend to explore this phenomenon from the perspective of child and adolescent psychotherapists working with these young people in a UK context, I would like to explore their own conceptualisations. It is hoped that my findings will be contributing to our knowledgebase in order to further future research that will address more nuanced differentiations in more detail.

Furthermore, the terms ‘young people’, ‘youths’, or ‘adolescents’ will also be used interchangeably to refer to the period of life from 13-25 years of age. I decided to settle on this age range given that there is an increase of mental health settings in the UK expanding their age range in order to bridge this age gap between children and adult services. Therefore, they incorporate this early stage of young adulthood into their conceptualisation of adolescent development, which is not believed to sharply end by the time teenagers become formally adults, but to continue its struggles well beyond that.

I. Literature Review

1. Introduction

In this section I will report the methodology, findings and discussion of a comprehensive literature review I carried out with the overall intention to explore the existing literature in relation to a number of questions outlined below.

Given the complexity and breadth of this topic, I narrowed down the scope of this literature review to the most relevant areas for the research question. The aim of this literature review is indeed to gather more of an understanding of the ways Social Withdrawal has been conceptualised and made sense of in Asian and Western countries and during the phase of adolescence. It will also aim to include conceptualisations from a psychoanalytic perspective. A further aim is to understand the impact on adolescents of the Covid-19 pandemic, which imposed strict social restrictions for a period of time.

My literature review was guided by the following questions:

1. Hikikomori and Social Withdrawal increasing in Western countries: what are some of the characteristics and contributing factors?
2. Is it a clinical or a social phenomenon?
3. What interventions are there?
4. What is the impact of an external form of social confinement on adolescents: the COVID-19 pandemic?
5. What are the psychoanalytic concepts concerning retreats from relationships and life?

6. What are the psychoanalytic views on adolescence?

2. Methodology of the literature review

The focus of this review is divided into two parts. The first centres around empirical studies related to the area of Hikikomori and Social Withdrawal, and it addresses questions 1-4. The second explores psychoanalytic literature on the topics of Social Withdrawal and adolescence, and it addresses questions 5-6.

2.1. Empirical Studies

The first aim was to carry out a scoping review of the literature in order to identify quantitative and qualitative research studies on the topic of Social Withdrawal within each of the particular questions outlined above. As such, this review is primarily a scoping review guided by a specific question.

As pointed out in the introduction, given that the concept was first observed and named in Japan, it was important to include literature of studies carried out in Asia as well as other parts of the world, however, the review was limited in that it only included literature that was published in English.

Search Engines

The researcher conducted the literature search using ‘PsycINFO’, the ‘EBSCO Discovery’, as well as a general ‘Google Scholar’ search to get a sense of what had been researched about Hikikomori and Social Withdrawal, and where the gaps were. The focus was primarily on qualitative studies as they are most relevant to this research project. However, as the presence

of qualitative studies was limited, the researcher expanded out to include also quantitative studies.

Search terms

The keywords searched were: Hikikomori; acute/severe/prolonged social withdrawal AND adolescent/young/teenager; socially isolated AND adolescent/young/teenager; retreat AND adolescent/young/teenager; school AND refusal. Once the most relevant research papers on this topic were found, the researcher used a snowball effect, by using the references in those studies, to further the literature search.

There were numerous studies available in Western countries exploring further aspects of social withdrawal and social isolation, focusing particularly on their interrelation to issues of anxiety, depression, personality traits, social communication difficulties and developmental delays. While these are undoubtedly interesting areas, they are more relevant to a study on how Social Withdrawal is conceptualised in relation to co-morbidities, so they are not included here.

As outlined in the aims above, the researcher also focused on studies related to the COVID-19 pandemic. This is because the pandemic involved social restrictions that imposed a de facto temporary state of social withdrawal that greatly influenced young people during this delicate and transitionary phase of life. There was no space here for an exhaustive search on this wide-ranging topic. Studies on remote working or remote schooling were not included, as it was beyond the scope of this study to explore those aspects. The researcher therefore focused on the impact the pandemic had on adolescents and young adults' functioning and

wellbeing, as it is most relevant to the present study. The keywords used were: pandemic AND youth/adolescent/teenager/young.

2.2. Psychoanalytic literature

The second part of this review focuses specifically on psychoanalytic literature, exploring theoretical and conceptual models that either directly refer to the phenomenon or might help understand this phenomenon. The psychoanalytic idea underpinning a withdrawal from social relationships and even from life itself is the concept of 'Psychic Retreats' developed by Steiner (2003).

Search Engines

The researcher conducted the literature search using again 'PsycINFO', the 'EBSCO Discovery', and 'Google Scholar', as these contain a vast amount of psychoanalytic theoretical papers. The focus was solely on theoretical papers, therefore papers that included empirical studies were excluded for this part of the review.

Search terms

The keywords searched were: psychic retreats AND psychoanalysis/ psychoanalytic/ psychodynamic. First, the most relevant papers were selected, those that referred directly to the concept of 'psychic retreats'. As many papers referred to the concepts of 'destructive narcissism' and the 'death instinct', a further search was made with the keywords: destructive narcissism AND death instinct. Only theoretical papers were selected from the results the search yielded. The researcher used these initial papers as a starting point and then found further relevant literature on different aspects of the same topic through a snowball effect of looking at references and quotations. This search produced a rich body of literature on the

concepts of psychic retreats, where they stem from in relation to disruptions in early development, and the formation of narcissistic structures. These concepts are also heavily interrelated to numerous other areas of mental health and psychoanalytic defences that may arise from disturbances in early infantile life. The researcher therefore excluded those papers that related to psychic retreats but focused specifically on a different mental health disorder, such as eating disorders or personality disorders.

The researcher also searched for: adolescence AND psychoanalytic theory. This search was aimed at gathering literature on psychoanalytic views of adolescence in general, as a period of life extremely relevant to this phenomenon. Only papers describing the wider aspects of adolescent development were included, whereas those focusing on a specific topic, such as delinquency or migration, were excluded as they extended too far from the topic of the study. Again, a snowball effect was adopted to find further relevant papers from the ones initially selected.

3. Results of the literature review

3.1. Hikikomori and Social Withdrawal: empirical studies

I will now summarise and critically evaluate the empirical literature led by the first four questions that guided my search. The remaining two questions will be addressed in the second part of my review findings, the section dedicated to theoretical papers.

Question 1. Hikikomori and Social Withdrawal increasing in Western countries: what has the literature identified as some of the characteristics and contributing factors?

The literature review on these aspects revealed 26 studies, one of which was a systematic review and one a case study.

A global phenomenon

In 2010, the Oxford Dictionary (Stevenson) published a new entry for the word hikikomori, signifying its presence and acceptance outside of a purely Japanese context. However, the condition is now considered more global and perhaps it is better understood as a 'contemporary society-bound syndrome' (Kato et al., 2019).

Some global common characteristics have been identified in a systematic review by Li and Wong (2015) who carried out a systematic review of both qualitative and quantitative studies across different Western and non-Western cultures. They included both qualitative and quantitative articles due to this being a relatively new area of research and limiting to either type may have resulted in a small number of recovered studies and possibly offered a biased view. The articles they examined, although being from different cultures, were all written in English and had to be academic articles strictly focused on the phenomenon of youth social withdrawal. Therefore, from the 290 articles that their search yielded, only 42 were included in their review. Some of the common characteristics they identified include: engagement in solitary activity; lack of family support and secure attachments; limited friendships and romantic relationships; bullying and peer rejection; issues of fear, hopelessness and relationship fatigue; difficulties in finding a job to legitimate one's social status; and the perceived burden of social responsibilities and role performances. This systematic review is very important as it allowed the authors to state that social withdrawal has become a universal issue in many countries that are high-income, but face a shrinkage in their productive workforces and are ageing societies. However, a limitation of their review was that the authors did not assess for study quality and the risk of bias within and across articles

was not thoroughly investigated. As such, it is difficult to discern in how far the findings can be comparable.

Social and cultural aspects of Hikikomori

The literature identified in my review also stresses the importance of considering some of the underlying factors pertaining to cultural and societal aspects of Hikikomori. This is highly relevant to the growing research of this phenomenon in Western societies, which may have both commonalities and significant differences from Asian countries in cultural norms and values.

Some noteworthy studies explore, for example, how parent-child relationships in Japan have been considered less oedipal than in Western societies, as they often involve a very close and prolonged connection to the mother and an absent father, which may contribute to difficulties in becoming independent (Kato et al., 2018).

Caputo (2020) argues that in Japan, as in other collectivistic societies, social withdrawal may be more acceptable as values of cohesiveness and conformity often discourage externalising and socially disruptive behaviours. However, he also highlights the risk of underestimating hikikomori in some European countries, including Italy, where self-seclusion seems to represent an increasing habit among young people (Loscalzo et al., 2016). In fact, such condition could be present in the Italian context without being identified correctly, as Italian adolescents report high levels of social anxiety, whose hikikomori may represent an extreme expression. Recently, several private and public Italian services have started to treat some cases of hikikomori teenagers, who show reduced engagement with the outside world (Ranieri, 2015).

Sarchione and colleagues (2015) further suggest that a variety of global social and cultural aspects may explain the spread of hikikomori in Western societies, including individualism, the crisis of traditional values, high unemployment/underemployment rates, and the increase of communication technologies. In their analysis, they refer to this state of things as 'modern type depression', 'social anorexia', and describe how oedipal guilt is being replaced by narcissistic shame.

The paradox of the search for comfort in a claustrophobic space

A number of studies that adopted a psychoanalytic lens in their analysis have found very interesting themes about some the psychological dynamics of withdrawn individuals. Mohr (2021) conducted a noteworthy research study that included an audit and eight interviews with mental health professionals working with socially withdrawn young people in a London-based clinical setting. She set out to investigate whether the Hikikomori phenomenon present in Japan was also releavant in the UK, and she found a presence of 16% of overall referrals in a clinical setting having Hikikomori presentations – being shut away in their rooms - and a further 13% being at risk of Hikikomori. The researcher found and explored four overarching themes in her interviews: *being stuck, relationship to the outside world, boundaries,* and *therapy, change and endings*. In her interviews, amongst these themes that will be explored in other areas of this study, she interestingly found that clinicians experienced the therapeutic space with their patients as claustrophobic and their presence as a 'thinking third' could only occasionally and very gradually be admitted by their patients to create some space for separateness and development. Her study, although having a small sample size, offers a highly relevant snapshot of the Hikikomori issue in a mental health setting in the present-day UK in a holistic way, with her combination of quantitative and qualitative methods.

Ranieri (2018) reflects on his case study of a socially withdrawn young person in psychotherapy and writes about this phenomenon being more than a symptom for adolescents, but an attempt to find a solution to their difficulties with themselves and others. He explores how an adolescent boy going through a transitional period can experience withdrawal as an attempt to regain control over their environment, and gradually rebuilt a direction and their identity. However, he argues that this is a trap for the adolescent who becomes imprisoned in a complex psychic mechanism that impedes independence. The retreat has a suffocating essence and it fosters the establishment of a pathological personality organisation. Ranieri therefore distinguishes infantile play and daydream fantasies that belong to the transitional area, from those that hinder development and trap the young person in a claustrophobic space. In relation to psychotherapy, he discusses the many moments of impasse in the treatment, partly internal and partly due to family relationships and crystalized structures since childhood. He reflects on the presence of the therapist, which offers the possibility of and the hope for human contact, capable of receiving projections and allowing the formation of a certain dependence on a good object that can withstand attacks, have a difference of opinion and be separate. Ranieri stresses on the need for constant reflection on the false security offered by the pathological organization, and on the vitality of authentic relationships, whilst acknowledging the leap of faith required on the part of the adolescent to leave their retreat. This can be considered an important case study, contributing to our knowledgebase in that it allowed to explore in significant depth and detail some the conscious and unconscious dynamics at play in a socially withdrawn individual in psychotherapy.

Caputo (2020), in his analysis of autobiographical entries written online by hikikomori young people (N=17), found four latent dimensions of social withdrawal, revealing the conflicted and paradoxical nature of this condition. He found for example that there is a refusal of

intimacy and yet a suffering in not forming bonds with others, or a wish for independence and yet a retreat into a virtual space and poor autonomy to face competitive situations. He hypothesises a narcissistic component in these young people's search for comfort, as their identification with an omnipotent and ideal infantile world might avert deep suffering in facing reality. However, some limitations in his research need to be considered. First, the participants' self-selection bias in relating their own social withdrawal. Then, the related issue of participants being self-diagnosed rather than clinically assessed, therefore making it difficult to assess the clinical relevance and consistency of the sample. The lack of demographic information to maintain the participants' confidentiality also prevents from deepening exploration on some important areas. Finally, due to the exploratory nature of the study and the low sample size, the findings cannot be generalised, calling on future research to replicate this study with more participants.

Motivation for recovery and the omnipotent maternal nest

Furuhashia and Bacquéb (2020), following their analysis of their clinical practice with around 370 cases of Japanese students, focused on the examples of two young people with a similar presentation of social withdrawal but who responded to psychodynamic therapy very differently. They reflect on the factors that might have influenced these variations. They first identify the presence or absence of conflict, one patient felt discomfort about their own condition, and the other felt satisfied about it.

Secondly, parent involvement, with the first patient allowing his parents to attend, whereas the other patient refusing. The authors discuss how the relationship between patient and parents seems to mirror that between the patient and society. Whereas the first case is marked

by acknowledgement and engagement with a problem, the second case suggests an avoidance and refusal to allow them to enter his internal world.

The third factor relates to the expression of emotions, whether or not they convey them to others. They adopt Freud's (1924) distinction between melancholic patients who form a hysterical identification with a lost object continuing to emotionally invest in it, and those who form a narcissistic identification where the ego introjects the lost object and identifies with it, creating a stuck self-identity lacking distinction and separation from the object. The authors suggest that, the lost object being society, the first patient seems to have lost something as an object of love and attempts, even sporadically, to retrieve it, therefore presenting with a hysterical form of identification. The second patient has identified with the lost object and thus ceases to retrieve it, presenting with a form of narcissistic identification.

Finally, they reflected on the activities that the individual engages in during the withdrawal period, with reading and writing keeping something alive, and immersion into the Internet and videogames becoming addictive and constituting a hindering factor. They conclude that for the patient's social prognosis, feeling conflicted, involving parents in the therapy, expressing emotions and engaging in creative activities are necessary factors and conducive to treatment with psychodynamic therapy, whereas immersion in games and the Internet are hindering factors, as all these reflect the relationship between the patient and society.

These authors also reflect on another important element at play in relation to the possibility of seeking help and the young people not going under the radar, the feeling of 'shame' existing in the most important intermediaries between the individual and society, family and school, which can both at times hide the fact that a young person is not leaving the house or not attending school (Furuhashia & Bacquéb, 2020).

Furthermore, they analyse cases where the mother has developed a fusional preconscious relation with their child and there is a lack of paternal agency. They found two possibilities, too much lack leading to the father being unable to compensate the psychic state of the mother (depressed or schizophrenic), or an absence of lack, leading to the mother becoming idealised and omnipotent (later replaced by surrogates, like the internet) and the withdrawn individual living with the mother. The hikikomori 'nest' becomes therefore an accumulation of treasures and affective reminders, including virtual objects, which can become jewellery of the kind accumulated when stuck in the anal stage. However, the authors of this research do not provide any details for the methodology they employed in their examination of the 370 Hikikomori students in psychotherapy. Although they interestingly explore in detail an example from each of the two groups that emerged from their analysis, they did not explicitly write about the criteria for choosing these two particular cases and it is impossible to determine how generalisable their findings are.

In her study, Mohr (2021) also found that withdrawn adolescents go into a form of 'psychic retreat' into their rooms and computers in an attempt to find comfort from the feared outside world, perceived as dangerous and demanding. The clinicians interviewed also noticed how the adolescents did not seem to consciously experience any frustration about their stuck situation or any wish for it to change. On the contrary, participants reported the young people as feeling comfortable in their situation, unwilling or unable to change, and experiencing any change as frightening. Therapists, on the other hand, felt frustrated and despairing. Mohr interestingly hypothesises that therapists feel the frustration that the young people do not consciously feel, as being aware of it would be too overwhelming.

Contributing factors

The following literature considered factors contributing to social withdrawal:

In the already mentioned systematic review, In Li and Wong's (2015) examined and identified across both Asian and Western countries, several factors. First, factors associated with dependence, such as overdependence on parental figures (Borovoy, 2008; Suwa et al., 2003) or a retreat from the burdens of interdependence in society (Toivonen et al., 2011). Second, family factors, including nuclear families without support from extended family (Borovoy, 2008; Kaneko, 2006; Lee et al., 2013), a family member's death (Kondo et al., 2013), broken families (Chong & Chan, 2012), and parenting and family dynamics that are dysfunctional (Chan & Lo, 2016; Heinze & Thomas, 2014; Suwa & Suzuki, 2013; Suwa et al., 2003). A third factor identified related to high expectations for academic achievement (Hattori, 2006). Finally, behavioural factors were also uncovered, particularly young people being asocial or selectively social, therefore maintaining some communication with online people, family members or people unconnected with their work or life (Suwa & Suzuki, 2013). However, the articles mainly featured the comments and perceptions of socially withdrawn youths and did not investigate biological factors that may be associated with socially withdrawn young people.

A longitudinal study (Choi et al., 2020) focusing on the impact of the broader social environment on social withdrawal, found that despite negative child-rearing attitudes being a crucial factor, negative peer relationships have an even greater influence on withdrawal for adolescents. Their findings in fact suggest that parental 'laissez-faire' attitudes or parental overly protective bheaviours in raising their children could lead to later social withdrawal among adolescents. However, they found that negative peer relationships due to constant peer refusal can be internalised, contribute to a lack of confidence in interpersonal relationships,

and can lead to social withdrawal. Gazelle and Rudolph (2004) suggested that social withdrawal experienced during childhood could persist into adolescence; however, it may also be ameliorated through improvements in peer relationships.

The increased importance of social interactions during adolescence and young adulthood can make social withdrawal during these ages particularly problematic. This is highlighted in Barzeva's research (2019) of 1917 Dutch adolescents assessed at four points from the age of 16 to 25 years. Overall, participants followed a U-shaped trajectory of social withdrawal, where withdrawal decreased from ages 16 to 19 years, remained stable from 19 to 22 years, and increased from 22 to 25 years. Additionally, three distinct trajectory classes of withdrawal emerged: a low-stable group (71.8%) that was highly adjusted, a high-decreasing group (12.0%) which had the highest social maladjustment, followed by a low-curvilinear group (16.2%).

A very interesting study (McCullagh, 2020) analysed the narratives of young people aged 16 or over who told their experiences of social withdrawal. Their narratives showed the importance of specific incidents over longer-term tendencies. Certain 'Catalytic Events' were associated with significant changes in their experience, such as moving home, starting new educational settings and confrontations in the social context of the classroom. Furthermore, young people were found to have an awareness of change and continuity across early selves, continuing selves, withdrawn selves and future selves.

Question 2. Is it a clinical or a social issue?

The second question of interest to explore concerned whether hikikomori can be considered a clinical issue, therefore requiring a diagnostic framework and treatment, or whether it is

considered a social issue that may not need conceptualization as a mental disorder. The literature review on this aspect produced 14 studies, including a systematic review and two case studies.

While psychiatrists such as Kato and colleagues (2012) have considered social withdrawal in young people an illness that may require hospitalization and medication, Caputo (2020) points to ideas that hikikomori should be considered a state of being rather than a psychiatric disorder. This argument considers hikikomori as a complex social phenomenon that may be ascribed to the impact of socio-cultural influences including limited economic options, reduced social development and lack of support structures (Allison, 2014). It also emphasises how often people not in employment, education or training (NEET) voluntarily refuse the mainstream values of a globalized and post-industrialized society and decide to withdraw as a form of protest (Uchida & Norasakkunkit, 2015). Sarchione (2015) refers to the economic and working recession as possible underlying factors for the NEET phenomenon. In fact, although Hikikomori is a distinct phenomenon to NEET, some sociologists have described it as another social issue of young people (Furlong, 2008).

A study (Husu & Välimäki, 2017) of young Finnish people that identify as hikikomori, explores the dualism between psychology and sociology, and particularly how wider social settings inform and construct individual choices. In exploring these young people's reasoning for their withdrawal, the article reveals how experiencing external society as demanding and lacking resources such as education, social networks or the personality type that they see as valued in society and as essential to 'survival', were the most prevalent themes. The study proposes that psychological factors (depression, anxiety) can be considered as properties of social relations rather than as individual states of mind. These ideas point to the necessity of interventions at a societal and political level.

David McGill (1987) has coined the term “social anorexia nervosa” to describe this form of self-destructive social withdrawal and school refusal, as a symptom of intergenerational and societal distress in modern Japan. He provides the formulation that this is the “refusal” generation who are rejecting or questioning their role as a reaction to a culture-specific psychological distress, ‘amae-ko’, which means being raised without learning to depend or lean on someone else. Further research (Todd, 2011) suggests the point of view that there is a national existential angst and that these young people are ‘retiring from their society into the womb of their rooms’ (p.141).

De Luca (2017) highlights how hikikomori is described in the DSM-5 as a cultural idiom, namely a contemporary expression of distress in the transition to adulthood for certain adolescents who are confronted with strong social and family demands. Through his search of Japanese scientific literature from the 1980s, he found that the confrontation with a distressing and demanding ideal can lead to suspending the ideals of the Ego and fostering massive inhibitions, to then be driven to seek refuge in passivity. The author argues that classification of hikikomori as a cultural idiom can therefore integrate its dual cultural and psychopathological aspects.

Some authors have proposed a differentiation between a primary form of hikikomori, which implies behavioural problems rather than a mental disorder, and a secondary one, consisting in a pervasive developmental disorder (Li & Wong, 2015).

Pozza and colleagues’ systematic review (2019) identifies different strands in the debate, with some researchers who support the idea of cultural aspects being at the core of this syndrome and other authors considering it a clinical issue. Authors then divide into subgroups depending on whether they see it as a secondary symptom of other mental health conditions or a new primary psychiatric disorder in its own right.

A diagnostic framework for severe social withdrawal

Following on from the above debate about whether hikikomori is a new clinical disorder to be distinguished from others despite some overlap, the question arises as to whether a specific diagnostic framework is then needed.

Kato and colleagues (2019, 2020) have indeed introduced their latest assessment system for hikikomori and have proposed a diagnostic criteria of hikikomori for future DSM diagnostic systems, suggesting the need to assess the severity and to identify milder forms in those who leave the house 3-4 times a week.

Furthermore, a quantitative research project (Dzik, 2019) has also established, in their systematic review of the literature, that there is no set of standard measures used as a gold standard in the research exploring this condition. As the review pointed out the lack of unified outcome measures and streamlined definitions of social withdrawal, in her qualitative study clinicians helped to develop a scale to identify and assess social withdrawal in young people in Scotland in order to then test this new measure in a clinical setting, therefore involving clinicians' opinions in a UK context. The feedback from clinicians not only helped to further refine the proposed Glasgow Hikikomori Scale, but indicated an engagement and interest in CAMHS professionals in the topic of social withdrawal. However, the engagement of withdrawn young people testing the scale was extremely limited. The data therefore was not sufficient to conduct statistical analyses and determine the properties of the scale. Further research requiring significant longer times for recruitment is suggested by the author.

Question 3. What interventions are there?

The third question guiding my literature focused on interventions. This scoping review yielded 9 studies, one of which was a systematic review and three were case studies.

This literature review showed that there is very limited research on the efficacy of treatment for this condition. In fact, intervention for individuals experiencing social withdrawal is very complex, due to nature of their condition and their tendency to avoid contact with others.

Indeed, Li and Wong (2015) suggest that the lack of a diagnostic tool and formal definition of youth social withdrawal results in a limited number of cross-cultural observational and intervention studies. They further suggest a new framework for understanding social withdrawal and its required interventions. They conceptualised a first type of socially withdrawn young person, the 'overdependent' type, who is raised in over-protective families and does not develop autonomy healthily. These youths are the most withdrawn, avoiding all interactions and remaining in their bedrooms. The authors suggest that they need intensive individual psychotherapy to work on their delayed development and relieve their anxiety and emotional distress. Family therapy is also recommended. The second type is the 'maladaptive interdependent' who faces dysfunctional parenting and family dynamics. These young people end up having unsatisfactory inter-personal relationships as they have not learned enough skills and withdraw following peer rejection or bullying. They may leave home occasionally but often drop out of school. These young people are suggested to require support groups and social activities to resolve their social conflicts. The final type is the 'counter-dependent' withdrawn person who is over-burdened by high expectations of achievement by the family. When they fail or opportunities lack, they withdraw to search for meaning in life. These young people are considered to possibly benefit from educational or work-related skills programmes. However, all types are in danger of causing prolonged withdrawal which then causes further deterioration and diminished interpersonal skills, therefore requiring a

psychological therapeutic intervention before a social one. However, this systematic review mainly incorporates articles revealing socially withdrawn young people's own perceptions and ideas, and it lacks quality checks in the articles it is basing its framework on, especially around tested and solidly researched interventions.

A study (Imai et al., 2020) shows that only 56.7% (n=34 of 60) of participants defined as 'current' Hikikomori (those currently withdrawing) attended therapy in person, compared to a significantly higher percentage of 'past' Hikikomori (those beginning to access the world again), 92.6% (n=75 of 81; $p < .001$). The 'current' state predicted significantly fewer regular visits; however support from psychiatric social workers increased visits. Finally, among the 'current' Hikikomori patients, first visit attendance in person predicted regular attendance.

Other studies suggest that early intervention is important, for example a case study of 38 Hikikomori patients revealed that the factor which had an impact on prognosis for university hikikomori students was early intervention (Furuhashi & Furuhashi, 2014). However, no further information can be gleaned from this suggestion, pointing to the need for further research to explore this.

Most studies show that a combination of different approaches might be beneficial to treat this hard-to-reach population, rather than the use of one individual approach. Silić and colleagues (2019), for example, found that a number of therapies (including individual and group psychodynamic therapy, CBT, and psychoeducation) combined with low doses of medication yielded the best results for this type of psychopathology. Ranieri (2015), based on two clinical case studies, also argued that a single approach is not sufficient and a combination of different clinical and educational approaches is needed in order to create a network that can foster the resources of the individual, the family and the social context. He argues that social

work and home interventions are also extremely valuable. He states that the results of his study highlight the need to increase clinical knowledge on this syndrome.

Ranieri (2018) also discusses the presence of the psychotherapist based on his case studies. He argues that this presence, not thought of as separate by the patient and not too significant, offers nonetheless the possibility of human contact that can receive the patient's projections. It becomes gradually possible for the patient to establish some dependence on a good object capable of resisting destructive and envious attacks. He also emphasises the number of obstacles to the therapeutic process, which are partly internal to the patient and partly due to family relationships that react to any modification of the structures that have been crystalized since childhood.

Interestingly, a study (Furuhashia & Bacquéb, 2020) explores two types of mental functioning in hikikomori patients, one that combines withdrawal and psychic conflict and the other is characterised by avoidance of psychic conflict. The researchers found that the first type are treatable with psychodynamic therapy, whereas the second type are difficult to treat with the same treatment and they are closer to psychosis and borderline cases.

Finally, Mohr (2021), in her research combining an audit and interviews with therapists in a London mental health setting, found that severely withdrawn young people can engage in psychotherapy, and can slowly be helped in that way. This was based both on the number of patients taking up the psychotherapy offer and on the clinicians' interviews. She subsequently suggests three necessities: that more resources are allocated to long-term treatments for these patients, alongside the shorter ones that are becoming more common in mental health settings; that help needs to be implemented at the stage when an adolescent is at risk of dropping out of school, as it is a crucial step for further deterioration and withdrawal; and to

increase provision of services up to the age of 25 to bridge the gap of entering young adulthood, where withdrawal can often crystallise.

Question 4. What is the impact of an external form of social confinement on adolescents: the COVID-19 pandemic?

There is also a growing body of contemporary research on the impact of the COVID-19 pandemic, suggesting particularly the deleterious effect on young people caused by isolation and social restrictions. There are therefore interesting parallels between internal and external forms of social isolation during the complex and delicate phase of adolescent development. The scoping review of the literature on this aspect revealed 9 studies, one of which was a systematic review.

A study (Velez et al., 2022) exploring US adolescent experiences of the pandemic has shown three themes in relation to their socioecological context: the interconnection of daily routines, social life, and mental health; the inadequacy of virtual means of communication; and missing out on key experiences and milestones. Limited socializing, therefore, contributed to the disruption of everyday life. Hawes and colleagues (2022) found an association between home confinement concerns and increased generalized anxiety symptoms. Further research (Luijten et al., 2021) reveals the serious mental and social health threat that governmental regulations regarding lockdown posed on children and adolescents.

Kiss and colleagues (2022) highlight how adolescents with pre-pandemic psychological problems were most affected and how important social connectedness and healthy behaviours, such as sleep and physical activity, were as buffering factors against the deleterious effects of the pandemic on adolescents mental health. Another study (Branje &

Morris, 2021) also demonstrates how many adolescents experienced negative affect, loneliness, increased depressive symptoms, and lower academic adjustment during the pandemic, particularly those that were already at risk before the pandemic. A further study (van Loon et al., 2021) on 188 Dutch adolescents who were assessed before the pandemic and at eight and ten months into the pandemic, also focuses on pre-pandemic risk factors. The researchers found that adolescents who had vulnerabilities before the pandemic (i.e. internalizing problems, maladaptive coping, or higher stress) experienced more concerns during the pandemic. A study (Li et al., 2022) on the impact of the pandemic on Australian teenagers showed that three quarters of the sample experienced a worsening in mental health, affecting mainly family relationships, friendships and learning. The effects were worse for people with a previous diagnosis of anxiety or depression.

Research focusing particularly on eating disorders (Spettigue et al., 2021) shows that compared to adolescents assessed for an eating disorder in 2019, those seen in 2020 presented with higher rates of nutritional restriction and functional impairment, were significantly more likely to be medically unstable, and required more urgent consultations or hospitalizations.

Finally, a systematic review (Stavridou et al., 2020) of 21 studies on the psychosocial consequences of COVID-19 in children, adolescents and young adults, indicates that the situation imposed by social distancing and isolation could be a risk factor for deterioration in mental health, including distress, depressive and anxiety symptoms, fear, post-traumatic stress, and insomnia. Behavioural changes have also been identified in children and adolescents with neurodevelopmental difficulties, such as autism spectrum disorder (ASD), with children losing their independence and communication skills or engaging in problematic

interactions with their parents, and attention-deficit and hyperactivity disorder (ADHD), with children becoming uncontrollably angry and unable to perform everyday tasks.

3.2. Psychoanalytic conceptual and theoretical models for understanding withdrawal states

The final two questions that guided my review were addressed in this theoretical section. The review of the literature revealed six concepts that could be related to the phenomenon of social withdrawal and an additional psychoanalytic view of adolescence. These will be briefly summarised and discussed below.

> Question 5. What are the psychoanalytic concepts concerning retreats from relationships and life?

Psychic retreats

The withdrawal from the world could be conceptually understood in psychoanalytic terms as a form of what Steiner (2003) calls a 'psychic retreat'. This concept involves the difficulty of tolerating one's own dependency needs and therefore also accept a certain degree of separateness from important caregivers. Certain individuals who struggle to tolerate this vulnerable and painful position can then turn away from relationships all together.

It contains the paradox of withdrawing from connections with others and yet ending up in a position of pseudo self-sufficiency, which actually leads to utter omnipotent dependence (i.e. for sustenance, shelter, and the need for care and attention in worried others). Several authors describe how this mechanism is the basis for the formation of narcissistic structures in the internal world (Joseph, 1982; Rosenfeld, 2008; Steiner, 2003). The hikikomori condition

seems indeed to suggest an element of this paradox of choosing self-isolation and yet creating a relationship of external dependence on parental figures, as so often the withdrawal takes place in the parental home.

Steiner (2003) argues how this defence arises from unresolved conflicts in the early stages of life where the capacity to rely on a dependable containing other and then gradually separate to become an independent growing individual are negotiated.

Transitioning from the maternal world to the outside world

In relation to the process of separation from a primary object in the early years of a person's life, Winnicott's (1953) renown concept of the transitional object is central to this process and highly relevant to social withdrawal, where the transition from inside to outside is problematic. In fact, Winnicott describes the infant's gradual need to move from a maternal world to the outside world and how this complex painful process of growth often requires a transitional object or phase, where the infant carries with him something that represents the mother, and therefore begins to tolerate their absence in certain situations. These young people returning to their bedrooms, seem to have difficulties in transitioning to the outside world, perceived to be too overwhelming or uninteresting. They seem to be stuck in a developmental phase that does not foster outward movement toward growth, separateness, and a fuller life. Research on hikikomori has indeed often identified the concept of 'amae', an over-dependent child-parent relationship, as a significant cultural aspect of this condition (Kato et al., 2018).

The triangular space that allows for separation and growth

Another important process in early mental life that implies the development of the capacity for separation and tolerance of feelings of exclusion concerns the Oedipus complex, moving from a dual mother-baby relationship to a triangular space, where there is a wider space for growth, individuation and creativity (Britton, 1989). The Oedipal situation begins with the recognition of the parents' relationship and it implies the relinquishing of the idea of permanent and sole possession of the mother, which gives rise to a profound sense of loss and it needs to be mourned. The acceptance of this psychic reality is necessary for the psychic growth of the individual, and when this cannot occur, oedipal illusions may be created (Britton, 1989). The consequences of this on one's own emotional life are a pervasive sense of unreality and a constant feeling of unfulfillment in relationships and projects in life. The capacity to envisage a benign parental relationships leads to the creation of a space outside the self, a 'triangular space', that offers the possibility of observing and in turn being observed and thought about, creating the basis for a stable secure world (Britton, 1989). This is very interesting in the context of the claustrophobic retreat of these young people into their rooms or homes, and the way they seem to make themselves invisible to other people and society.

Maternal containment: a secure base to leave

Moreover, Bion's (1985) theory on the function of containment is also extremely relevant, as it also stresses the link with the maternal object and how secure that feels to the individual to be able to venture out into the world with a sense of trust and resources, something socially withdrawn young people seem to struggle with. In fact, he describes the failures of the maternal containment and argues that when the mother fails to take in the child's projections, it is experienced by the child as an attack, and this impairs his communication and link with

her as a good object. When this happens consistently, it impairs the individual's development of an internal capacity to contain difficult emotions and the challenges of growth and life.

The capacity to be alone

Winnicott (1958) has very interesting ideas about the capacity to be alone and how it is dependent on the capacity to be in the presence of someone. He discusses how the basis of the capacity to be alone is a paradox, as it entails the experience of being alone while someone else is present, a sort of sharing solitude. He argues how a person may be in solitary confinement, and yet not be able to be alone, then suffering beyond imagination. According to the author, solitude is distinct and free from withdrawal. This concept is very interesting in relation to withdrawn young people who confine themselves to a state of solitude but are not necessarily able to be alone with peace of mind. This requires the ability to separate from the object and then carry the object's presence inside the mind, therefore transitioning in and out of moments of solitude and moments of connection with others. These young people instead tend to 'cut off' from other people in an attempt to deny their connection with them. Winnicott further analyses the phrase 'I am alone', saying that 'I' suggests that the individual is established as a unit, therefore integration and emotional growth are a fact. Furthermore, 'I am' suggests that the individual has not only shape but also life. A protective environment facilitates the individual's achievement of the 'I am' stage. Finally, 'I am alone' involves the infant's appreciation of the mother's continued existence. Over time, the actual external presence of a mother or mother figure can be forgone but it remains as a good protective internal figure. Winnicott argues that the pathological alternative is a false life based on reactions to external stimuli.

The formation of narcissistic organisations

One of the pathological alternatives that may form when the processes of separation are interrupted is the formation of narcissistic structures. Steiner (1982) argues that when a move towards a dependent relationship is made, the narcissistic organisation, if present in the individual, prevents access to and encourages violent attacks against the object and the needy part of the self. Therefore, not only it impairs the prospect of freely relying on others but also the capacity to acknowledge and accept one's own feelings of dependence.

Steiner bases his ideas on the concept of 'destructive narcissism' coined by Rosenfeld (2008) who argued that there some destructive parts of the self that often remain split off or silent, however maintaining an extremely powerful effect in preventing dependent object relations and in keeping external objects constantly devalued, which accounts for the apparent indifference of the narcissistic person towards external objects and the world. Steiner (1982) further argues that these destructive tendencies have links with the death instinct and he refers to clinical cases in which the patients present with extreme deadliness.

Joseph (1982) goes as far as to suggest that there is a prolonged state of deadliness in certain individuals. She indeed describes the external lives of certain patients, who get increasingly absorbed into hopelessness and become involved in activities such as avoiding eating properly, poor sleep, overworking, drinking or cutting off from relationships. She explored how this seemed to have an addictive quality and coined the expression 'addiction to near-death' (Joseph, 1982). The 'near-death' element is related to the fact that these individuals do not long for actual death. They seem to long for the satisfaction of seeing themselves in a state of misery. She found in these patients a type of mental activity that involved going over and over again about failures and happenings in an accusatory or self-accusatory way in

which they become absorbed. Joseph argues that these individuals are in the grip of a part of the self which imprisons them, even though they may see life outside their cavern.

In these cases, “reality is neither fully accepted nor completely disavowed", and Steiner sees this as "a perverse mechanism designed to keep the patient's idealized and persecutory versions of himself and his objects apart" (2003, p. 88). The attempt to lie to oneself about reality interferes inevitably with the ability to accept, value, and recognize the “facts of life” - specifically, “one's dependence on internal and external objects, generational differences, the creativity of the parental couple, and finally the inevitability of time and ultimately of death" (Money-Kyrle, 1971, pp. 103-106). Adams (2018) explores the idea that a retreat from reality can be understood as a retreat into an anal world, where there is absolute control over the object and differences are denied. This is very restrictive for creative spontaneous life and risk-taking involved in real intercourse. Edna O'Shaughnessy helpfully introduced concepts of “enclaves”, where there is over-closeness, and "excursions", which are tantalising digressions, to describe modes of relating designed to avoid facing reality and any real emotional engagement (1992, pp. 604-605).

Steiner (2006) also highlights the fascinating processes of ‘seeing and being seen’ and the related feature of self-consciousness, which are also central aspects of narcissism. He argues that the individual feels hidden and protected by a narcissistic organisation, so when this diminishes, he is obliged to tolerate a degree of separateness and he now feels exposed to a gaze that makes him vulnerable to humiliation. Supporting the person to understand and tolerate this humiliation is the only way development can take place, according to the author.

Projective identification

Another very important psychoanalytic idea that relates to both early processes of growth and psychic retreats is projective identification. This concept centres on the way communication with the other occurs and it is therefore extremely relevant here. It has been grappled with and expanded on by several psychoanalytic authors. Here, two aspects of this concpet are the most pertinent. The first one is Klein's idea of projective identification used for controlling the object, elaborated by Segal (1975). Kleinian theory in fact sees this phenomenon as another mechanism of defense, which operates in the very early phases of life and can re-emerge later on in life. The theory explains that parts of the self are split off and projected into an external object, which then becomes identified and controlled by the projected parts. One function could be to get rif of the bad parts of the self and relate to them externally in the object to control the source of danger, or to attack the object. Another function may be to expel good parts of the self to keep them safe somewhere else as there is a sense of damage inside, or to make the object ideal to avoid separation. In fact, these young people seem to struggle to face their own impotence and powerless in many situations and the people around them are often made to feel those emotions on their behalf. These adolescents, indeed, through their passivity and unavailability end up exercising significant control over their objects, who often keep them constantly in their mind, worrying and feeling helpless. This relates to psychic retreats because there is again a lack of capacity to tolerate a genuine separate relationship that involves the risk of the other coming and going, having a separate mind and not always be available.

The second aspect relates to Bion's (1970) ideas. Although in his theory there is still an expulsion of intolerable parts of the self into the other, he also maintains that this could offer an opportunity for understanding and recovery. Indeed, the individual is able to communicate these split off parts of the self as the other can feel them on their behalf, and the other can

therefore help the person make sense of them and retrieve them. This function can indeed be used therapeutically.

Question 6. What are the psychoanalytic views of adolescence?

Psychoanalytic views of adolescence are also particularly relevant to this topic, as it is evident in the literature presented that social withdrawal affects adolescents particularly. Hoxter (1964), amongst others, writes about a resurgence during adolescence of phantasies and feelings that previously characterised early childhood. She argues that the adolescent is faced with the task of turning to others outside the family and relinquishing the parents as the original sexual objects. Freud stated that "the individual recapitulates and expands in the second decennium of life the development he passed through during the first five years" (1953, p. 234). Whereas the young child is protected and limited by parents, however, the adolescent can feel scared of the real possibility of acting on their sexual or aggressive thoughts and feelings. Adolescents may then resort to defences of a pathological nature. Indeed, there could be a difficulty for adolescents to differentiate between mature and infantile aspects of sexuality, leading to a fear of growing up due to a fear of regressing to uncontrolled expressions of infantile sexuality. The conflicts and dangers that they project into the external world, can be helped to be internalised back by the therapist.

Coren (1997) agrees to a widely accepted view of adolescence as a period of upheaval and confusion where conflicted wishes need to be negotiated. He also speaks of earlier phases of development being reworked, however he interestingly thinks that it happens in reverse order. In fact, he argues that in early adolescence there is a process of self-preoccupation, often in relation to one's changing body and the realization of one's separateness, that lead to a reworking of the Oedipal stage of development, negotiating triangles. In mid-adolescence,

crucial issues of independence and autonomy arise, suggesting the link with issues of autonomy, control, pride and shame typical of the anal stage of infantile development. Finally, late adolescence is concerned with matters of identity and the 'self-in-the-world', possibly re-arousing infantile primary anxieties of establishing a sense of self in a benign rather then malign world.

Waddell (2018) speaks about the rapidly changing worlds young people inhabit now, which exacerbate the already existing emotional disturbance of adolescence. She argues that these are very troubled times, psychologically, socially, politically and ecologically. According to the author, young people are already caught between lost childhood and unrealised adulthood and are torn between opposite wishes. They are in a phase of protracted separation crisis that involves considerable mourning, for lost childhood, lost dependency, lost certainties. Therefore, adverse external events – such as illness or death in the family, parental separation, job loss, internet grooming, bullying – that ordinarily can be experienced as traumatic can have an even greater destabilising consequence in this phase of life. Furthermore, Waddell distinguishes between "classic" (2018, p.157) narcissistic mechanisms and the narcissistic splitting and projection that are part of ordinary adolescent exploration. She argues that to avoid the emergence of pathological narcissism it is necessary to work through narcissistically structured relationships, both within the self and in relation to others, in order to develop the capacity for individuation and separateness.

4. Conclusion of the literature review: What's missing?

The findings of this literature review suggest that, since Saito's (Tamaki & Angles, 2013) initial investigation of an increasing number of young people shutting themselves away in their rooms, there has been increasing interest and research on this topic in Japan and other

countries in recent years. The international body of research clearly shows that this phenomenon is present in other countries, where the term first identified in Japan as ‘hikikomori’ is most commonly referred to as ‘social withdrawal’ in English or as other translated versions and it has been subject to substantial quantitative research. However, this review suggests that this is still an evolving field and it is early days for the literature on this topic. Several gaps in the literature have been identified in this review:

- There is a lack of coherence in the conceptualisation of this phenomenon through global research across several countries, particularly related to the question of whether it is a culture-bound phenomenon and therefore different in Japan, wider Asia, and other Western countries.
- There is a lack of agreement in the literature on whether this is a social issue, related to the pressures of capitalistic contemporary societies and therefore needing social reforms, or a clinical one, potentially requiring a specific diagnostic and intervention framework.
- There is growing quantitative research, particularly in Asia but also in Western countries. However, this research often lacks clinical depth. The few qualitative studies found, provided fascinating psychoanalytically-based findings, however they are limited to low generalisability.

Future research is needed to provide more coherent views on the emergence and growth of social withdrawal in Western countries. Indeed, a more coherent, accepted definition and conceptualisation of this phenomenon are necessary for any more robust quantitative investigation of treatment options, for example RCTS on the effectiveness of relevant

interventions. However, in order to contribute to that aspect, first detailed qualitative investigations are required to begin the task to derive at a conceptualisation.

This study indeed aims at achieving greater clinical depth in exploring this phenomenon in mental health clinical settings in the UK by interviewing Child and Adolescent Psychotherapists. The hope is to be able to provide helpful implications for further research and clinical practice.

A study very close to the present one is Mohr's (2021) research on socially withdrawn adolescents seen in a mental health clinic in London. She first conducted an audit to establish the presence of socially withdrawn young people in the patient group of that service. Three years later, this study does not include an analogous audit, as it accepts the presence of this patient population in London clinical settings. Similarly to Mohr's (2021) study, the present research involves interviews with psychotherapists working with such withdrawn young people. However, the focus of the present study is broader and includes an examination of therapists' understanding of these adolescents' external lives and circumstances, such as family structures, contributing factors, or the impact of the pandemic, as well as an exploration of the experience of delivering therapy to this patient population, as Mohr (2021) also investigated. It will be interesting to discover if the findings of this research will be comparable to Mohr's (2021) results in relation to therapists' experiences of working with withdrawn adolescents and their reflections on unconscious dynamics at play in the therapeutic encounters.

II. Empirical Study

1. Introduction

The principal aim of my research study is to begin to contribute to a conceptualisation of youth social withdrawal from the perspective of the therapist. The present project is indeed an exploratory qualitative study aimed at gathering the perspectives of psychoanalytically-trained Child and Adolescents Psychotherapists on their understanding and experiences of working with socially withdrawn youth in mental health settings. A second key aim is to base my research study in a UK context, which requires further exploration of this important topic. In fact, although this phenomenon was first identified in Japan (Tamaki & Angles, 2013), the estimated prevalence of this phenomenon in the general population worldwide is believed to be 1.5% (Pozza et al., 2019).

2. Methodology

2.1. Selection of research participants

Participants included four psychoanalytically trained Child and Adolescent Psychotherapists who worked in a CAMHS service and a specialist adolescent outpatient unit in London. I approached participants from this discipline because they train specifically to work with the age group I was interested in for this study. Additionally, I was interested in the deep thinking about conscious and unconscious dynamics that psychoanalytic psychotherapy can offer and the clinical approach psychotherapists have, in their search for the roots of the problem and the reasons behind the development of particular symptoms (Rustin, 2009). This way of thinking is compatible with the aim of the research project in exploring this phenomenon in depth and detail, including unconscious processes that may have arisen in the participants'

clinical experience with their patients. The participants selected were either qualified or in training. This is because the participants' extensive experience or seniority was not the central focus of this study, which instead was to understand the experiences of working with a hard-to-reach population, socially withdrawn young people. Therefore, including trainees allowed for a greater opportunity to recruit participants able to offer the relevant patient experience.

The two clinics where the research took place are both Tier 3 teams. Therefore, the Child and Adolescent Psychotherapists who participated in the study were embedded in a clinical context characterised by a multidisciplinary team and were indeed used to confronting themselves and collaborating with colleagues from Psychiatry, Clinical Psychology, Specialist Nursing, Family Therapy and so on. The participants therefore had knowledge and experience of working within a network of other professionals.

The researcher approached all Child and Adolescent Psychotherapists working in the two clinics previously mentioned and for which ethical approval was granted. Following an initial email from the researcher, the Child and Adolescent Psychotherapists who expressed interest were provided with further information about the research project[1]. All the participants who then responded were selected to participate in the study. A total of four therapists were recruited, one from the specialist adolescent outpatient unit, and three from the CAMHS service. When participants agreed to participate, they were given a copy of the interview questions in preparation for the interview, so that they could begin reflecting on the relevant cases they had worked with[2].

[1] See Appendix C: Public Facing Documents
[2] See Appendix D: Interview Schedule

2.2. Ethics

Ethical approval for the study was received from the Tavistock Research Ethics Committee (TREC)[3] on 24.05.22.

At the start of the interview, participants were given another copy of the Participant Information Sheet and were asked to sign the Informed Consent Form[4]. When the interviews were conducted remotely, participants were emailed the Participant Information Sheet again and were sent the Informed Consent Form to be signed and return by email ahead of the interview on the same day. Interviews were audio-recorded and anonymised by the researcher. The interviews and anonymised transcripts were kept on a secure NHS server, separate from the list of participants.

2.3. Research setting

The geographical setting for the study consisted of two environments, a CAMHS service and an adolescent outpatient unit, both situated in London. As the literature review shows, there is a gap in qualitative studies in Western countries, particularly in a UK context and with a focus on clinicians' perspectives within existing mental health settings specifically. London, as well as being where the researcher works and lives, and was therefore chosen as a specific city for practical reasons, is also the largest metropolitan city in the UK, therefore providing ample opportunity to explore this topic in two of its mental health settings.

Another important reason for this setting choice concerned the age group of the affected population needed for this study, which is adolescence and young adulthood. Indeed, research suggests that from a developmental perspective, hikikomori typically emerges between the

[3] See Appendix A: Trust approval
[4] See Appendix C: Public Facing Documents

ages of 16-25 years old (De Luca, 2017). This could be due to the extensive developmental stressors and challenges that face adolescents, including expectations for increased independence from the family, and pressures for societal conformity and educational and occupational attainment (De Luca, 2017). However, prodromal symptoms often emerge during early adolescence (Pozza et al., 2019). The two selected settings, in fact, allowed to include therapists' experiences with younger and older adolescents in CAMHS (13-18-year-olds) and older adolescents and young adults in the Adolescent outpatient unit (16-25-year-olds), therefore incorporating the entire age range of adolescence and young adulthood.

2.4. Interviews

The interviews were semi-structured and took place either in person at the CAMHS clinic and the adolescent outpatient unit, or remotely via video link, subject to the participants' preference and availability. They were conducted between June and September 2022. The interviews took 60-90 minutes.

The semi-structured interview covered the following areas and broad questions[5]:

1. *Characteristics of withdrawn young people*

   Can you tell me a little about the young people you work with or have worked with who present with symptoms of social withdrawal? Do you have any specific examples?

2. *Characteristics of family, school and social context*

[5] See Appendix D: Interview Schedule

Can you tell me a little about their families and how they usually approach the situation? Do you have any examples?

Based on your experience, what is their school situation?

And their social lives? What is their relationship with friends and peers?

3. *Characteristics of the phenomenon*

Given your experience of working with these young people, what do you understand of their difficulties?

What do you understand of the factors that lead to their withdrawal? And the warning signs?

How do you make sense of this phenomenon?

What has been the impact of the pandemic and the lockdowns on them?

4. *Experience of young people with symptoms of social withdrawal*

How do you experience these young people?

What feelings do they provoke in you whilst working with them? Do you have any specific examples?

5. *Experience of working with this phenomenon*

What types of intervention have you offered?

In your experience, how do these young people normally engage?

What is their families' involvement?

In your opinion, what are the major barriers to the work?

And what do you think works well?

What has been your experience of the impact of the pandemic and the lockdowns on the work?

What support system have you had during this period?

6. *Future*

What hopes do you have for a possible outcome of the treatment, based on your experience?

What else do you feel is needed to work with this particular patient group?

2.5. Interpretative Phenomenological Analysis

The data was analysed using Interpretative Phenomenological Analysis (IPA). This study kept its roots in the foundation aspects of IPA as outlined in Larkin, Flowers and Smith's book (2009), however it followed the most recent version published by Smith and Nizza (2022) in relation to the new terminology and ways of structuring the data analysis.

Although a range of qualitative data analyses could have used, included Grounded Theory (Birks & Mills, 2022), for example, the analysis of choice was IPA. It was felt to be an appropriate method of analysis for this study because it aims at understanding a small number of participants' lived experiences and understanding of them in the context of the worlds they inhabit (Larkin et al., 2009). This research project aims indeed at exploring participants' understanding and lived experiences of working with young people presenting with social withdrawal in the context of their working places in mental health settings. IPA is a method widely used in the field of psychology (Smith & Nizza, 2022), and by providing the opportunity of exploring a topic in-depth based on experiences and their understandings from the points of view of the people living them, it is highly relevant to psychotherapy and a

psychoanalytic lens too. IPA is based on the idea that "people are 'self-interpreting beings'" (Pietkiewicz & Smith, 2014, p. 8) and it attempts to reveal conscious and unconscious aspects of the participants' responses, which can emerge by identifying and analysing clusters, recurrence and connections between themes.

Furthermore, a small sample size, would not be fitting thematic analysis (Braun & Clarke, 2022b), but in the context of an IPA approach, there is the advantage of the data being analysed in greater detail. Indeed, participants' narratives about the young people they have seen could be explored and examined very carefully with details about their cases contributing to enrich the overall understanding and experiences in greater subtlety and accuracy. The intention of using this method of analysis is not to provide a conclusive, generalisable answer, but on the contrary to raise additional questions and stimulate further exploration.

The data was collected through semi-structured interviews, in order to allow the researcher flexibility in adjusting the initial questions and responding to the participants' responses to pursue areas of interest that emerged from the participants.

Interview data was all transcribed by the researcher. The data was then analysed using IPA in several stages, following Smith and Nizza's (2022) new terminology. First, the researcher recorded their first thoughts and responses to the data in their exploratory notes alongside the transcript[6]. Then the exploratory notes were examined to form experiential statements. Subsequently, the experiential statements that emerged were transposed[7] and examined for

[6] See Appendix E: Transcript and Initial Stage of Analysis
[7] See Appendix E: List of Experiential Statements

relationships with each other, and they were therefore organised into clusters[8]. Finally, clusters were used to inform Personal Experiential Themes for each interview. Numerous Personal Experiential Themes were identified within each interview[9].

The researcher then transposed the Personal Experiential Themes from all four interviews into a table to identify whether themes occurred across interviews[10]. The recurrence of themes was analysed[11] and a note was made of which themes recurred in at least half the sample[12].

Based on this information, and the researcher's own sense of how frequently certain themes recurred across interviews and in each interview, the final main themes and their subthemes were identified.

It is important to note that in forming and grouping themes, the researcher included the participants' own emotions and thoughts, including their countertransference feelings, as well as those they attributed to the young people and families they treated (i.e. the frustration they may have felt in their countertransference and the frustration they identified in their patients). Indeed, these thoughts and feelings are all part of the participants' ideas and lived experiences formed through observation and therapeutic contact.

2.6. Subjectivity

In accordance with IPA methodology, I have attempted to acknowledge the potential influence of my own identity throughout the research process.

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[8] See Appendix E: Clusters of Experiential Statements
[9] See Appendix E: Personal Experiential Themes
[10] See Appendix F: Thematic Tables: List of all themes
[11] See Appendix F: Thematic Tables: Identifying recurrent themes
[12] See Appendix F: Thematic Tables: Themes present in half the sample

There are several reasons for my interest in this research topic, pertaining to both professional and personal realms. However, acknowledging them feels as if the premise of the study might be undermined: might my own emotional relationship to the research subject lead me to make wrong assumptions about the significance of the subject matter? Nevertheless, an exploration of a topic that seems to be growing in London mental health settings, that of youth socially withdrawn and not accessing education or work, seems to be relevant regardless of my own feelings about it.

The subject of Social Withdrawal was indeed inspired by my own experience of the lockdowns during the COVID-19 pandemic, where social isolation was imposed for a prolonged period of time. Meanwhile, I also observed similar struggles in patients in my work places with a consistent increase of distress the longer the pandemic-related social restrictions took place, and for quite a long time even after they were lifted. These painful and thought-provoking experiences inspired me to think further about what the experience of working with socially withdrawn youths would be like. However, the development stage of this field of research was accompanied by frequent misgivings and fears, including the reluctance of delving into the project at times. There was a fear around whether my inevitable subjectivity as the researcher would bias my interpretation of the results.

In order to mitigate this risk to some extent, IPA methodology encourages the acknowledgement of one's own feelings about conducting particular research (Larkin et al., 2009). This important practice is also referred as 'bracketing' (Tufford & Newman, 2012), which consists of explicit ways of recognising the researcher's own ideas and feelings throughout all stages of the project with the aim of limiting the effect of unacknowledged

preconceptions rather than attempting to suppress them in the name of objectivity. As a lone researcher, it was difficult to recognise potential blind spots. Therefore, thoughts and feelings were acknowledged throughout the project journey not only within myself but also with colleagues and supervisors in research supervision groups. Peers and supervisors encouraged me to confront the impact of embarking into such a project and the reasons for the delay of the data analysis process, for example, as it would mean immersing herself in painful ideas and concepts. Indeed, bracketing also protects the researcher from the cumulative effects of examining emotionally challenging material (Tufford & Newman, 2012). IPA (Larkin et al., 2009) also encourages the use of exploratory notes during the data analysis process, to express and note down any initial thoughts and perceptions of the data. Indeed, this process allows for feelings and first impression to be noted down so that are not unconsciously filtering the participants' lived experience through the researcher's own personal experience (Tufford & Newman, 2012).

3. Findings

3.1. Overview

The interview data clearly shows the complexity of this topic as it uncovered multiple aspects of Social Withdrawal emerging from the participants' descriptions. These varied from attempting to grapple with an understanding of this growing issue and the young people presenting with it, to sharing experiences of treating it, particularly focusing on barriers, such as inaccessibility and limited resources. There was also the recognition of the helpfulness of some approaches. The data therefore addresses both aims of this research, to gather participants' understanding of the phenomenon and what it is like to work with young people presenting with it, all based on participants' lived experiences of treating these young people and their families in London mental health settings. Using IPA, the researcher identified five main themes, with their relevant sub-themes. These are explored in more depth below.

3.2. Recurrence of themes

The extent to which themes specific to individual participants are also shared by other participants can be examined if adopting IPA analysis (Larkin et al., 2009, 2021). This helps to identify group experiential themes from experiential themes belonging to each interview. The researcher thus calculated which themes recurred across data sets and found that eighteen themes were present in over half the sample[13]:

- An escalation from school refusal 4/4
- Adolescents and younger children transitioning to secondary school 4/4
- Parental mental health difficulties and intergenerational trauma 4/4

[13] See Appendix F: Thematic Tables

- Systemic barriers to recovery 4/4
- The need for long-term interventions 4/4
- Working together 4/4
- Gradual recovery 4/4
- Boys are mainly affected 3/4
- The role of the pandemic 3/4
- The trigger of added external pressures 3/4
- Collapsed space for growth 3/4
- Between cutting off and dependence 3/4
- Withdrawing from life 3/4
- Anger and frustration 3/4
- Serious concerns around young persons' wellbeing 3/4
- The experience of inaccessible young people 3/4
- Boundaries and separation issues in family relationships 3/4
- Ambivalence about recovery 3/4

The researched found an additional four themes that were present in half the sample:

- Hopelessness for a way forward
- The power of a flexible approach
- Fostering contact with reality through boundaries
- Complexity of an entrenched problem

3.3. Main Group Experiential Themes

The researcher formed five main group experiential themes with subthemes by connecting recurrent themes, using abstraction of certain ideas (i.e. systemic barriers to recovery, complexity of an entrenched problem, the experience of inaccessible young people) and subsumption, where one umbrella includes different themes (i.e. parental mental health difficulties and intergenerational trauma, the trigger of added external pressures, the role of the pandemic – all under the umbrella of 'contributing factors'). It was difficult at times to determine where certain themes from individual data sets and across data sets most accurately nested in relation to the main group experiential themes. For example, aspects of the contributing factors are largely connected with the entrenched nature of the problem and to some characteristics of the young people's retreat from life. The main group themes are therefore interrelated and their division is inevitably somewhat untidy and overlapping. However, in their non-linear way, they represent the overarching ideas that reflect participants' views, thinking and experiences of working with young people presenting with social withdrawal.

The main group experiential themes and their subthemes are presented in Table 1.

Table 1: Main group themes and corresponding subthemes

1. The what and the who	- School Refusal - Male adolescents and younger children
2. Contributing factors	- Parental difficulties - Added external pressures - The pandemic

3. A retreat from life	- Between a wish to connect and cutting off: a denial of dependence - Collapsed space for growth - Withdrawing from life
4. An entrenched problem	- The emotional impact - Barriers to recovery
5. The road to recovery	- Interventions - A gradual recovery

The group experiential themes and their subthemes will be outlined below. There will also be a selection of direct quotes to exemplify and evidence the subthemes.

Theme 1. The what and the who

This theme is about gathering the shared understanding of what this phenomenon is and who is affected by it, based on the participants' experiences. The first subtheme captures some of the ways Social Withdrawal was described by participants and how it is recognised for what it is by them as professionals in the context of a mental health setting in London. The second subtheme focuses on the age group and gender of the young people.

<u>Subtheme 1a. School Refusal</u>

School refusal seems to be what triggers referrals to mental health care and when the problem is considered to need further attention. In the interviews there are many reports of young people who suddenly dropped out of school or whose problem in referral letters was described as ‘school refuser’.

Participant 2

It's a an interesting description ‘social withdrawal’, because we can see social withdrawal in a number of presentations, that then we describe in a kind of… clinical way, you know in generic CAMHS. But what comes to mind in terms of social withdrawal, it's very much it's uh one big group of the kind of umm young people that uh are socially withdrawn. Uh, the young people that come to CAMHS are because they are school refusing.

Participant 4

So he went back to school and then around the time of his A-levels, then he dropped out of school and was out of school for like 2 years.

In the examples below, it is possible to see how, in some cases, anxiety about school attendance was clearly present before reaching the point of school refusal. Participants indeed conveyed the discomfort that young people report feeling while still accessing school and social relationships, and it is described as a collapse from social contact.

Participant 3

She [adolescent girl] managed to start school in January, but she attended a few weeks where the TA was allocated on a very reduced timetable, so she would go for one lesson a day and then that will be it, a lesson and a lunch break.

I think what we've kind of discovered with the parents is that she would hold herself together when she was going to school, but she would come home and she would absolutely collapse.

Participant 4

So like for example, sometimes he [adolescent boy] will come back from college and he would be so tired that he would just drop in bed and lay there. And like, he couldn't even, he can't even sit up to look at his phone and he just lies there.

Now, having started working with him, the anxiety about social interactions was very much present before he dropped out to school, and he always found the school very difficult and feeling a lot the pressure to perform and feeling in constant competition with others.

The withdrawal that begins with school refusal then escalates further to a more serious reclusion, leading to staying in bed, not leaving the house, cutting off from friendships.

Participant 4

[…] he was isolated, not only he wasn't going to school, but kind of cut off any relationship from his friends, he spent most of his time in his bedroom, in his bed, raising the anxiety of his family.

Participant 2

Okay, so the length of time he stayed out of school increased and also he withdrew from friends. The other group of friends. He was going out still even when not going into school. He withdrew more and more and he fell into a difficult depression. Very difficult depression.

You know, it's all, he was refusing to get wake up in the morning, to get up from bed [….].

Participant 1

So by this point, A's [adolescent girl] college course had ended. […]. What emerges then is that she's not leaving the house. Barely leaving the bedroom.

Subtheme 1b. Male adolescents and younger children

All participants mentioned that a mixture of girls and boys were affected, however all stressed that the majority were males. One participant mentioned a transgender young person who was biologically female but identified as male.

In relation to the age group, although participants were asked to think about adolescent patients between the ages of 13-25, they highlighted that younger children were affected too. The younger children were seen as particularly affected when they transitioned from primary to secondary school. It could therefore be noted that they are pre-pubertal children at the verge of hitting puberty and at a period of change and further separation from the nurturing

environment of primary schools to larger, more independent, and often chaotic secondary schools.

> *Participant 3*
>
> *I've got another two ones, these ones again at the process of transition from the primary to secondary and one is the boy who I saw once, in fact, in the last summer term. […] I know that they were hoping that he would get quite a lot of support around transition to secondary school and settling in. […] I feel that the transition from primary to secondary school is immense.*

> *Participant 1*
>
> *Umm I think A seems to have coped with primary school. I don't think she was ever happy, but she coped. Secondary school… […] by that stage, she realised that she had gender issues. So I think that complicated life at secondary school. […] Yes, I mean in the early years of secondary school she was under the radar.*

Theme 2. Contributing factors

The next finding that emerged from the data relates to contributing factors. The complexity of this theme is evident in all the data across all participants as it involves multiple interdepended aspects. For example, parental mental health difficulties may have been influenced by intergenerational trauma and may in turn affect issues of separation and boundaries with their own children. It is beyond the scope of this research to determine exactly what may cause this phenomenon. However, of note was that participants grappled with their own attempts at understanding some of the aspects they have noticed in the young

people's families and in some of the situations that preceded young people's withdrawn states.

Subtheme 2a. Parental difficulties

This subtheme was present in all the interviews and it relates to parental and family difficulties of various nature. Three emerged as important, these include:

a. parental mental health difficulties
b. intergenerational trauma
c. separation and boundaries issues

a. The first element concerns parents having their own vulnerabilities, especially mothers:

> *Participant 2*
> *You know when you have the script of 'school refusal' and uh in exploring and in in having an assessment, it emerged there was extensive and long term parental mental health.*

> *So, again, this young woman […] seemed to be caught up in this system where there was a mum with her own mental health needs and fighting quite a lot of the people that were trying to help.*

> *I think with mum [of another boy]z there was something of a sense of loneliness underneath this very capable professional woman.*

Participant 4

We didn't know for months that mum is agoraphobic so she doesn't leave the house. She actually doesn't leave the bed. And apparently they both [parents] suffered from anxiety on and off.

It also concerns parents struggling to bond with their children and provide the care they need, or even causing abuse and neglect:

Participant 1

So the picture is of mother preoccupied and her mind elsewhere. I think materially mother provided for the family. And one's sense is that she cooked quite nicely and there was food on the table, but from my contact with mother now, she cares for A [daughter] but can't really understand her. […] I don't think there was much softness going on between A and her mother.

And I suppose that also her isolation, you know, that there's a history of her… especially children of a parent, really, you know, she's got an abusive father, and the mother who parents a certain aspect of what she needs, and there are whole swathes of care, the mother can't provide.

Finally, it concerns a conflictual relationship between the parents in the house:

Participant 3

So because, for example, one case that I'm thinking about, umm, there were difficulties between parenting styles for quite a long time. Mum seemed quite kind of

tuned into this young person's needs. Dad seemed to be more of kind of boundaried and expecting things and stricter. And the boy would clash with dad.

There were in fact thoughts of how unresolved and unaddressed difficulties in the parents affect the children's capacity to feel they have a secure stable base to start with and feel safe and confident enough to venture out of to live their own lives.

Participant 2

And I wonder, you know, so what is the function of the social withdrawal, the school refusal? You know, in this particular case it feels like very defensive, you know, 'I need to protect myself'. In my mind, you know, 'my secure base feels so unsafe and so unpredictably so...' you know as with parental mental health it is so unpredictable, at least in these two cases, so it feels that the secure base doesn't feel secure, in depth secure, it feels precarious, quite unpredictable.

Participant 4

[...] I mean both my patients are really anxious and perhaps the child can't quite contain their anxiety because that's their experience of others that can't contain their own, you know, anxiety.

b. The second element that emerged in relation to parental difficulties refers to intergenerational trauma, therefore suggesting how far back and how unconscious the issues carried by individual family members may go.

Participant 1

I think there was domestic abuse in the grandparent generation. And grandmother had separated from grandfather.

Certainly back then, people from that country were much more victims of the regime quite often tortured or so, that I suspect with him there was probably some intergenerational trauma.

Participant 2

It was a very painful situation because as I got to know about them and their situation you could see that there was not just the maternal mental health long-standing and the conflict in her environment that she had created, but also there was an intergenerational picture of trauma, yeah? So this young person had to deal with such a huge amount of pain and trauma in her own family and extended family for some time.

Participant 3

There was a in history of family trauma. In the past, mum had to be the carer for her parents when she was growing up. And she became very protective over her daughter when she was small, to a point when she wouldn't allow her to, you know, to fall even, you know.

Participant 4

And both their parents [the parents' parents] were alcoholics, so they had quite a few traumatic episodes, and there were a few traumatic episodes in the boy.

c. The final element that emerged in relation to parental difficulties involves issues of separation and boundaries within the family. Indeed, many descriptions of family situations revolved around an enmeshment between parent and child and a difficulty in creating boundaries with their children, instead trying to filter the world outside for them and minimising their discomfort.

Participant 2

She was spending a lot of time in her bedroom uhm... I can't remember more than that, but in that situation, there was also a lot of reluctance and ambivalence... uhm both for mum and daughter to be seen.... uhm you know for me to see the daughter by herself.

[…] when she was with mum she would be, she would come across, and resonate with me, as a much younger child. And then in the in the bedroom by herself, you know, in the appointment with me, she would come across as much more her age... uhm and more capable... yeah almost as though there was a need to remain in that younger position to fulfil mum's views of her, you know, projections in a sense.

Participant 3

The parents are separated. And you know, I I had a sense of a quite enmeshed relationship to some extent. […] So there was a lot of kind of adjusting, a lot of kind of translating for this young person, umm a lot of kind of negotiating between them and the world outside or any people outside. […] So I feel like this young person has never quite developed her own kind of resilience skills and her own kind of separate identity. She was always kind of in connection to mum.

Umm, but I think mum found it absolutely unbearable to let her [daughter] go.

Participant 4

Well there is something about social withdrawal and especially if they're hiding at home that is about separation from their parental figures.

The mum is seen for parent work and has been refusing to involve dad, despite the clinician's several attempts to involve dad. And apparently they've been talking about, uh, getting some help for herself as well. She needs a bit of therapy and help to separate from this boy.

Subtheme 2b. Added external pressures

This subtheme refers to additional pressures that young people presenting with Social Withdrawal and their families have had to face and may contribute to the difficulties of remaining out there in the world fostering social relationships. One very interesting question that emerged was related to immigration and what pressures immigrants and their children may have to carry with them in relation to building a safe successful life in the world they are in.

Participant 1

I wonder whether partly what's going on with this, and a couple of the other patients is that they're second-generation immigrants. And there's pressures on immigrants or children of immigrants.

‘Not knowing what to do next’ is another aspect discussed, particularly in relation to older adolescents, at times feeling unsure about what they enjoy and feeling the pressure of having to succeed.

Participant 1

Well, I suppose there's a number of strands […] Moving out of London to this little town, it's a very different world… and so it would have felt very very different. Also I think she finished her college course and didn't know what to do next so it’s not like she was on a clear path. So I think those are the things that tip it.

Participant 4

He’s [older adolescent] really torn because there are some things that he likes, that he would like to do. But then he’s worried that he might not perform as well, so there isn't much about liking something and enjoying doing it. It's about doing something and achieving perfection.

In the younger adolescents, as well as the transition to secondary school already mentioned, participants described young people struggling with exams, particularly GCSEs. As can be seen in the examples below, these are perceived by participants as tipping points often precipitating a withdrawal. Participants suggest that additional pressures cannot be faced when the young person is already under strain or having difficulties, as they require a strong solid stable base to withstand them.

Participant 2

And then in conjunction, for example, with the first young girl that I mentioned, the 15-year-old girl, she was approaching GCSEs, she was extremely stressed about that, and she was not very much believing in her own capacity, academic capacity, and even if she was, you know, managing quite well. And uh so her own, let's say stand-alone stress in relation to school, kind of linked up with this long-standing sense of instability, and not so secure sense of safety in relation to her mum. So it all kind of tumbled up, yeah?

Finally, one participant shared another interesting idea about the experience of spending a forced period of time at home and the subsequent withdrawal from school, questioning whether it created the temptation to regress into an avoidance of separation and growth. This absence was not in connection with the pandemic but with an illness, however it ties very strongly with the pandemic-related lockdowns where there was a forced period of time at home, which contributed to many difficulties in integrating back, as it is explored in the following section.

Participant 4

[…] at some point he [older adolescent] got sick and so he was out to school for a month or something. And then after that he found it quite difficult to go back to school […] and was out of school for like 2 years. […] And this is all my fantasy, it might not be true, but like the fact it's quite striking that he spent a month at home, perhaps kind of cuddled and looked after, perhaps a bit like a baby, and then he went back into school and couldn't quite you know, process the separation and go forward with his development, he was perhaps too tantalized by regressing.

Subtheme 2c. The pandemic

All participants shared the view that the pandemic constituted an important contributing factor to the young people's withdrawal. Most of them reported several young people where there were difficulties present already but the lockdowns created a forced withdrawal and isolation that they then carried forward beyond the duration of the pandemic. Some participants noticed how it suited some young people already attempting to hide from the world. Some participants thought that during such a delicate phase of development, an upheaval of that nature can cause a loss of an identity that was still forming, the loss of skills to manage anxiety and social situations that require constant practice, and even the reawakening of old traumas, such as the premature death of a parent. These reflections are clear in the examples below.

Participant 1

I don't know whether she would have withdrawn without COVID. […] For somebody who finds it difficult being in the world COVID was a gift. […] So, of course COVID suited her. She was very good at articulating it, 'actually COVID has done me a real favour, I can stay at home, I don't have to see anybody. And actually, my view is congruent with the world, I'm doing what I'm supposed to be doing. This is great'. And then if she did have to go out, it suited her to go out in a mask. Because people couldn't see her face that much.

Participant 2

So that's, I think, that's very interesting because I hadn't thought in this way, but I think, you know, the forced sort of lockdown, I think really did something to this boy and rewoke an old wound [the early loss of his dad]. And then yeah, the

reapproaching of normal life or school after the lockdown ended became an impossible task for him.

It's a quite destructive kind of way. Yeah. Because at that point, you know, he [different boy] was quite ambitious and had done fairly well academically. And he was losing his capacity, he was losing his grades. And so the idea of going back into school felt terrifying as though he had lost his identity of a capable, sociable boy. And then, it seemed that the safest, but in a destructive way, but the safest way of surviving was to isolate himself in almost this double isolation that he suffered, you know, before with the lockdown.

Participant 3

I think the moment that there was this longer break [pandemic lockdowns], it almost feels like she completely unlearned her kind of skills to manage the anxiety. […] It felt almost like she kind of lost this kind of resilience and everything became just too much and she couldn't pick up herself from the same, you know, position.

Theme 3. A retreat from life

Participants also shared views about some of the aspects they have observed in young people socially withdrawing. They all noticed and reflected on a sense of young people needing to retreat from the complexities of life and find a way of surviving without really fully living life. In fact, some young people, although suffering in their state of anxiety and wanting to get better, were found to be extremely ambivalent about actually re-joining the social world. Their ambivalence was also observed in their way of relating to another, especially to a parental figure or therapist. They were indeed observed to find themselves between a wish to

connect and a wish to cut off, without managing to find the right distance from the other. Their need for material sustenance and for a prominent presence in the other's mind, even when in the form of worrying about them, was found to be in contrast with their difficulty in tolerating their dependence leading to withdrawing from those relationships. However, this seemed to cause them to remain in a limbo between the two, as solid actual independence comes from the recognition and working through of dependence. This struggle between these two extremes, sometimes enabled by the parents' own difficulties, was considered by participants to narrow the needed healthy space in relationships for separation and growth. The young people were observed to search for forms of retreating away from liveliness and presence in the world, such as invisibility, anonymity, sometimes going as far as actually wishing and attempting to withdraw from life itself.

Subtheme 3a. Between a wish to connect and cutting off: a denial of dependence

This subtheme, as explained above, relates to the participants' understanding of the complex ways in which withdrawn young people may relate to others and what issues may arise in those relationships, particularly highlighting a difficulty in managing dependent relationships that would allow to then separate from primary parental figures and achieve greater independence. The young people seem to instead not tolerate dependence and attempt at achieving independence by cutting off. Three aspects of these complex dynamics will be outlined below with their relevant examples from interview extracts:

a. Ambivalence about connections

b. Too close or abandoned in relationships

c. Avoiding conflict

a. This aspect relates to the conflicted view in withdrawn young people about their wish to connect and cut off at the same time.

Participant 2

[…] uh the boy was so interesting, going back, and he would come to an appointment and he would say 'I think I'm ready, I think on Monday I will go and I'm looking forward to this and that and see my friends' and you could see how there was this life force in him, you know, really wanting that to happen, but the it wouldn't happen, despite, you know, all sort of support, referrals to all sorts of agencies, you know the early help agency has a particular team dedicated to reintegrating children being out of school for a little while, for example. But it didn't work and actually he withdrew more and more.

Participant 3

I think every term she would try to go so she would manage to go for 1–2 days and then she would collapse again. And then when there was a break, because I think there was a part of her that really wanted to go back, but she just could not get herself in that position.

Participant 4

And perhaps, in therapy, talk about the mixed feelings, on one side the wish to withdraw or not to be in connection with others, and on the other the wish and the need to actually be connected because they're hanging on to whatever relationship they have in their mind and can't let go of.

b. Participants also thought that these young people may struggle with being in an inevitably dependent relationship, such as one with a parental figure, and then separate and find the right distance to grow more independently.

Participant 4

I think it is one of the other reasons why he was socially withdrawn [friendships], it's that the moment that he gets close to someone, he becomes completely obsessed by them, they become the centre of his mind, and sometimes he realized afterwards that he's been thinking about them all the time. And it's a relationship where no one can ever move, because the moment that they talk to someone else, he gets jealous and so he feels completely abandoned, replaced, like a nothing, and that his self-esteem hangs with the behaviour of this other person.

Participant 4

There are some moments where he can talk, he stays really vague. And then there were lots of months in which he just sat in silence. And I was given this feeling that he will stay there and if I were to ask more questions, he would feel intruded upon by me. But if I were not to ask any questions, I would have abandoned him with his problems. We spent months like this. […] And with time we started to realise that what he's scared of is getting close to me. He won't allow me in and the risk is to get into this push and pull relationship. […] I think there's something where he is the one that decides the distance, he can keep me at a distance, he doesn't attend or doesn't talk or doesn't tell me things so that we can't get into that kind of close relationship. He can't meet me, and then he doesn't have to feel this jealousy. […] he can't quite align

himself to feel the level of jealousy and possession, and how abandoned he feels when someone is not there 24/7.

c. The third aspect suggested by the participants concerns the related point of these young people wishing to avoid any conflict, aggression, or competition that is an ordinary part of separate relationships.

Participant 1

So staying in bed. And the other thing was that her family were keeping reasonably normal hours. So it meant that she wasn't having to face her mother. Also mother's partner, and then at times, grandmother would be staying with them. So she was avoiding them. […] In fairness, I think A was then reacting to mother. […] I think there might be something a little bit masochistic about her.

Participant 2

Because he ended up staying, you know, spending the whole time in his bedroom, not wanting mum to come in. So he was almost like seeking refuge in this extreme isolation, you know.

Participant 4

And then mum arrives home sees him [older adolescent] there and panics or starts to go in, try to convince him to get out of bed, opening the windows. And he gets really angry. And then he doesn't move even more, and mum panics even more. […] Well, that's interesting because perhaps the withdrawn is active, the withdrawn is, in a way, taking control. Both patients need control and they take it that way.

Participant 4

And then one thing is, when he [younger boy] opens the box and takes out the ball, I think my heart stops a little like waiting for him to throw it at me, but it never happens. […] There's something about... I don't know playing with the ball that you just have to act and react, you know, like you are aggressive or you defend, you know, there's something of a bit of a battle there and he doesn't…. he looks at it a bit puzzled like 'what's that?'

Subtheme 3b. Collapsed space for growth

This subtheme follows on very closely from the difficulties in relationships described above, especially concerning the complicated problem of separating to reach a more solid independence, which the young people described by participants seem to manage by cutting off and denying their dependence, when actually remaining very dependent and ever present in the parental home and the parental mind. In fact, this subtheme emerged from participants referring to a sense of lack of space for growth for the young people they see, where growing up and moving further from home, physically and psychically feels too dangerous. Sometimes, this is aided by the parents who may struggle with separation issues themselves. There are indeed reports of young people locking themselves in, such as in these examples:

Participant 1

[A boy] He'd dropped out of school, he would only go out in the evening on his bicycle and we worked out that the range from which he would leave the house would be no more than half a mile. So it was like he put a compass around his house. And that was that.

And so there's one occasion where the boy [different boy] refused to come down the stairs. And I ended up seeing father instead. And father was just accepting of this boy's situation, 'Oh, well, he believes the world is dangerous.' […] I do remember before he went to bed, he would make sure that everywhere around the house was locked. That the door was locked, and it had a lot of locks on the door too.

Participants also noticed these young people's need to be seen as younger and needy in several of their cases, and a refusal to take the next steps and growing up. These are some examples:

Participant 4

But, there is a need to keep a relationship with mum of a certain type, where he is really unwell and needs to be looked after and mum can't really… well she's not allowed to think of him as a grown up or like someone that can manage. He has to show that he can't manage and she needs to think that he can't manage and then he could get annoyed at her because he can actually manage and all of that. But the reality is that he is not relating to her like the 22-year-old that he is.

I think he was quite scared of doing well because the thing that he does when he needs to do well is 'he withdraws' and he doesn't work hard at the things that he wants to achieve. Umm. And I think he wasn't ready to make the next step. So like, which was separating and going to uni and growing up and becoming a man. This is a bit more present now, but still he's quite scared and I think he has a wish to go back and hide and stay at home and not move on. It's like a refusal to grow up.

One participant went as far as suggesting the very interesting idea that the retreat into the bedroom could be understood as a retreat back into the womb, which is the essence of not wishing for a separate space to grow.

Participant 2

I just had a thought that... you know now that we talk about this dynamic, you know, the tension toward becoming an adult, their own person, and the separation and the infantile being still very active... and almost these two states living together in their state of mind... Almost I wondered, thinking about social withdrawal and not being able to go to school and spending time alone, at home, you know, by definition they would spend time at home in their bedroom. So it makes me think about, you know that sense of going back into the womb. Yeah, that kind of developmental regression into the womb, so the social withdrawal, whatever manifestation it takes in the cases I have described, you know, remaining at home, not able to go out, not able to talk to friends. It's almost like going back into a womb-like situation and to try to recreate that sense of safety which is almost kind of lost, it is nowhere to be found.

Subtheme 3c. Withdrawing from life

Once again, linked to the previous subtheme of a lack of space for growth, this other aspect of 'a retreat from life' is even more directly relating to the participants' observation of a wish to become invisible, anonymous, and even to stop living in some of the withdrawn young people they worked with. These aspects can be seen from the extracts below:

Participant 1

It's about not wanting to be seen. So even when she's in the world she doesn't want to be seen. […] So she has very, very dark hair, very, very thick hair. And I've never seen both eyes at once. Even though I'd seen her in person in the clinic, because she always dressed in black, walked down the corridor when saw her here, slightly hunched, as though she didn't want to be seen. Had very, very thick, dark hair, not terribly long, but coming right across her eye, across her face. And when I saw her in person in the room, it would be hard to see her face. And on video this continued.

So just coming back a bit to names…. the GP said, 'Well, do you want another name? We can call you something else'[different from the birth name and second name she chose]. So she tells the GP she wants to be called C [a third name name]. So I say, I hear you want to be called C. She said, 'Oh, no, not really, I just had to think of something on the spot' [laughter]. So currently, and this is a real problem in terms of getting on with life, A, as I call her for the sake of something, has no name that she's happy with.

[…] And in fact, on one occasion, she described her breasts as cancerous growths. Yes, I must say that really, really rather stuck with me.

Participant 3

She would end up in A&E on a few occasions there was some self-harm, there was some kind of eating disorder issues, suicidal ideation.

Participant 4

Uh, and this is someone that I started seeing because of, of course, his anxiety, as well he's not thriving too well to develop, he's really tiny. It doesn't put on weight.

Theme 4. An entrenched problem

This theme that emerged from the data suggests how complex and entrenched this phenomenon is to work with. Indeed, although previous themes were also partly gathered through the participants' countertransference feelings and experiences in their therapeutic contact with their patients, this theme focuses more specifically on the experience of working with young people presenting with Social Withdrawal and their families in a clinical context. One aspect involves the emotional impact withdrawn adolescents have on people around them. This includes the powerful emotions evoked in the parents, as they play a crucial part in the recovery process and are the ones that participants often had to work with in the absence of the young people, and in the participants themselves. The other aspect explored relates to the barriers to recovery that exist, which also concern the participants' experience of working with so many obstacles and a problem that at times feels impossible to shift. Another related theme that could be formed and explored further is the presence of other diagnoses which further complicate the matter, particularly related to social communication difficulties, Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder. It is beyond the scope of this study to investigate their incidence and how they relate to Social Withdrawal. However, future research is needed on this relevant aspect.

<u>Subtheme 4a. The emotional impact</u>

Multiple powerful emotions were expressed by all participants throughout their interviews about the experience of working with withdrawn young people. They also expressed the

feelings that other people around their patients, particularly the parents, shared with them or showed in the course of their work with them. The most common emotions identified were:

a. Concern

b. Hopelessness and sadness

c. Anger and frustration

a. These young people's stuck situations provoked a lot of concern and anxiety in people around them, particularly their families and professionals they encountered. There are reports of mothers panicking and parents generally feeling very worried. These are some examples of the ways the participants were affected:

> *Participant 1*
>
> *And there'd be times when I was quite worried about A, I never thought she was actively suicidal, but there was a degree of self-harming, and there were times actually, particularly when I was on leave, she was sending me these emails that were decidedly suicidal…*

> *Participant 2*
>
> *I had the initial assessment, but I was quite worried about this child. The risk seemed to be medium-high, because he was quite low, he was very low and there was such a discrepancy between his rational wish of wanting to go and then you know the failure in even trying, you know, the little steps. He was refusing any kind of help and there was somebody from the early help team that was going into the home and he began to refuse that help as well. So basically I was concerned.*

Participant 4

I think he is the, well one of the ones that I feel the most anxious when, I mean, he's like this tiny thing really gentle, really, you know, cute and little and yet he makes me feel incredibly anxious, as if I'm getting everything wrong […].

b. Participants also felt hopelessness, despair, and profound sadness for the situation which at times felt might never be resolved. These feelings were often shared by the families and the young people themselves:

Participant 1

It felt, I must say, terribly tough work. I would have some sort of situation where you're on a video call […] and I'm thinking, 'Oh, Lord, I am halfway through' because she just felt so depressed. And that went on for months. And where are we going to go? And how is this going to be resolved?

Participant 2

I think he brought up this sense of... that's why I keep using the word 'abandonment', there was a little abandoned boy there, you know, the little boy of three or four... that was a bit abandoned and huge sadness. I think it brought up for me a huge sadness... a really huge sadness...

It was a very painful situation because as I got to know about them and their situation you could see that there was not just the maternal mental health long-standing and the conflict in her environment that she had created, but also there was a

intergenerational picture of trauma, yeah? So this young person had to deal with such a huge amount of pain and trauma. And it was very painful, yeah? So there's a lot of, uh, a huge amount of pain and suffering that one has to endure and support the system to endure, yeah?

Participant 3

I think they [the parents] would come and they would talk about how absolutely emotionally draining the encounters would be with their daughter.

c. Another powerful feeling that emerged in all interviews was a sense of frustration and sometimes anger in people supporting withdrawn young people, particularly their families but also professionals. There was in fact a sense of some active and intentional part in their passivity and the feeling that no approaches worked, leading to very abrupt decisions rooted in anger at times. There was also the related sense of needing to work very hard and walk on eggshells around the young people, who dictated their control over any possible encounter:

Participant 1

[…] partly because her mother, grandmother, and eventually mother's partner, became absolutely furious with this child in the bedroom doing nothing. […] And of course, this is totally at odds with mother's 'you have to make your way in the world'. And I think she sort of sees A as a parasite.

In the end, we did lose video because her mother was so hacked off with her being in the bedroom all the time on a laptop […] so she cut off the internet.

Participant 4

Well it's quite hard because it feels quite intentional. It's interesting because this boy doesn't get angry, but anger is something that is not quite accepted in his family. […] He makes me angry because he's actively withdrawing and acting a bit like what happens with mum, kind of keeping me in a certain situation where I can't ask him or I can't not say anything It is, it is very frustrating.

Participant 3

Well. Again, I felt like I was walking on egg shells initially. Umm so, because I've tried so many different things with her [long list of attempts]. So, you know, I kind of wanted to give her that control. So if maybe she felt a bit more in control, maybe she felt she could engage with me.

Subtheme 4b. Barriers to recovery

Several barriers to working with these young people and eventually help them recover have emerged from the data. Two aspects were particularly highlighted:

a. Systemic barriers

b. The inaccessibility of young people

a. This aspect relates to systemic issues, such as lack of resources to engage such complex patients, and how easily withdrawn young people fall through the gaps, their discomfort not noticed, and by the time help is sought, the problem is very entrenched:

Participant 3

[…] in order for example to offer therapy and help them create the space, I don't think CAMHS have capacity at the moment to do it. You know, we're told time-limited interventions, if they don't want to engage well then you don't, you cannot force them and you can't do the work without their permission in a way. And of course that would exclude a huge number of young people.

Participant 1

I mean in the early years of secondary school she was under the radar and of course maybe that's also an aspect of reclusive patients in that, you know they are introverted, don't make relationships easily, don't look for help easily. And so in that sense one could go under the radar.

Participant 2

Uh but the social withdrawal aspect of it, it's very much part of it by definition. You know, they are really struggling to go into school. They haven't been for quite some time, by the time they come to us.

b. This second aspect relates to participants' experience of seeing or attempting to see young people who make themselves quite inaccessible in different ways, including refusing to get to the clinic or having a very patchy attendance. The extracts below give some flavour to the experience of their inaccessibility even when they are in therapy:

Participant 1

With the telephone sessions, it was very hard, because there'd be these long silences. And I would say, 'you know, it's very hard on the phone, because you don't know

whether the silence that we're having is a useful sort of silence where we're sharing a feeling, or that the line has gone dead or I don't know what state of mind you are in'. And then eventually, we got on to video and it was the same. […] I think, partly maybe it's just safer not to talk, not give emotions away.

Participant 3

I really really struggled because she would not even move. She was absolutely frozen in the sessions. She would have her hoodie on, face covered, hair covering her face, so I couldn't even see the expressions.

Participant 4

He's [older adolescent] been able to open up a bit more […] and then at some point he just had to cut himself off. So like last time that I met him, he was withdrawn again, didn't speak for the whole session.

This patient has been quite hard to work with because he's also quite boring […]. Well, it feels that because in a way there's no colour. There's something about he doesn't use gender when he talks about people, so like he stays really vague, so you can't quite know his intent, like he says for example 'I can't tell you the gender of this person because you're gonna have an image of this person in your mind'. And it's very much like that within. I don't feel like I really know all the aspects of him because he doesn't bring them, he doesn't want me to see it. There's a bit of a grey image in the background sometimes. Because the reality is full of really strong feelings that he can't quite bring to me.

Theme 5. The road to recovery

Notwithstanding the complexities highlighted in the previous sections, participants still attempted to work with this phenomenon, often needing to be quite flexible and creative about their approaches. They gathered and shared their thoughts on what interventions they have tried and what might have helped some of the young people to recover. This section also includes the ways some of the young people gradually began to feel better and to make small steps toward re-engaging with the outside world.

Subtheme 5a. Interventions

There were many factors discussed by participants in relation to the interventions they had implemented and thought about. Four main aspects emerged particularly from the data consistently across all participants:

a. Long-term interventions
b. Working together
c. The power of a flexible approach
d. From separation and boundaries to contact with reality

a. The first aspect that became clear in the participants' descriptions of their work was that interventions needed to be long-term and often required ground work first before the young person was able to embark on an actual intervention. When an intervention could take place, it also required time and a predictable reliable space that could be tested but remained there.

Participant 1

[Patient seen for psychotherapy] Weekly. For about 18 months.

Participant 2

So, whilst as a team we were trying to identify how to support him and his mum, I offered a holding number of sessions. Uhm…. Let me just think… then he was referred to a CBT intervention to manage anxiety. By then, he was in a much better place and he was able to make use of that. […] But uhm so we needed to address, you know, the rapid decrease in mood first, and then he was able to access this specialized treatment for anxiety.

Participant 3

[…] it took me several months, over a year, working with the parents, supporting the parents to support the young person before she was in a position of accessing telephone calls. […] So a lot of kind of persevering with this young person and staying and trying and working with parents to kind of help her.

[…] and then initially it would be, I would call, and she would say, or mum would say 'she's in the toilet. She's asleep. She said she's tired. She can't talk'. And I think we both mum and I persevered 'okay, I'll try next week, I'll call again at the same time next week'. So again, giving her a bit of a containing predictable space in which I, you know, I would get in touch with her.

[…] it was a very, very long process. I then decided that actually, you know, I don't think that she [different adolescent girl] would be uh willing or keen to access therapy, although mum wanted. So I offered parent and child intervention for I don't

know, maybe two months, when we kind of put together the family history, the family narrative. […] And eventually, after that, I think it lasted until December, I had offered psychotherapy, and it was a little bit of going back, so selective mutism initially in the sessions, and building and building on uh in that time it kind of went parallel with her going to school and starting this new school.

Participant 4

[Older adolescent male seen for weekly psychotherapy] Two years.

I've been seeing him [younger adolescent male] for intensive therapy so three times a week, not for that long. It's been 9 months plus the assessment.

b. The second aspect common to all participants was the need to work in a joined-up way as part of a network, with the families, the school and other professionals involved. This was viewed as particularly important because often the first priority was to foster some re-engagement with school and the outside world by working together on flexible realistic step by step expectations. Indeed, schools' good pastoral care and flexibility around attendance targets were found to be extremely helpful in allowing these young people to feel that a little at a time was enough to begin with. Moreover, working with parents was seen was crucial, especially in relation to separation issues and boundaries.

Participant 2

There is a lot of joint up work that that that needs to be done and it's never just one uh intervention, you know, and that will help them.

My input was really trying to support the system, the network, in thinking about what this young person would need to be able to go back into school and do her GCSEs. And there were a lot of network meetings, so to think very jointly because it also in this way mum felt much more contained, where we were all speaking and we could hear her, where she was coming from, but also she could hear that we were there altogether to try to support her daughter.

You know, [it took] a lot of support and a lot of effort, but she was able to sit GCCEs, you know, obviously lots of specific conditions had to be offered. You know, she had to be in a quiet room and, you know, a lot of support was given in terms of creating conditions that she could tolerate and could and she could manage her own anxiety as well as doing the exams.

And what I said at the beginning I think is valid for CAMHS work, to think of the three aspects, the child, the family and the school […] So I think that's an important element […] not to take the child in isolation. There might be at one point, you know, that the child may benefit from individual psychotherapy or psychology, you know? But I think to start with, it's very important, following the assessment, to do some joined work.

Participant 3

I've never spoken to her because her mum said that she's also selectively mute, and there was a family support worker involved, so I've kind of worked around this young person, but not quite with this young person.

I feel that, for me, it's really important to kind of get everyone on board. So, you know, liaise with the school, talk to the teachers.

Umm but yeah, it takes a long, long time and you've got to have parents on board with that because otherwise it's absolutely impossible. And I feel that something like in my cases, you know, a few of them, that the first work is with the parents. […] Umm and working with parents as well to help them, kind of maybe to help them not to feel so demonized by everyone.

Participant 4

There's something about social withdrawal and especially if they're hiding at home that is about separation from their parental figures. So I think perhaps with the younger ones, parent work is the main thing, maybe to kind of help the parents allow the child to separate and thinking about what is happening […]

c. Flexibility has also been observed by participants to help interventions immensely, for example, seeing the patients at home when possible, offering remote sessions to begin with, and being more active in conversations.

Participant 1

He couldn't get into the clinic. In the end, I went down to the home.

They live very close, so he could have walked here. And in the end I thought, 'Okay I'll see this boy at home'. And I would go and see this boy in this tiny bedroom.

I suppose there's two elements. One is she's [different adolescent] the one who made the overture to me. She's the one who writes anonymously. basically saying, 'I need help'. Doesn't tell me how to contact her, of course, doesn't make it easy. But I feel like it's sending up a distress flare, 'I'm in trouble'. And so maybe at that point she needed to be responsive to help or to want to form an alliance. And then I think for A it's easy to do that by phone. She doesn't have to see me in person.

Participant 3

[…] And I was very mindful not… I had to do quite a lot of talking, I had to structure our conversation quite a bit, so she wouldn't kind of really talk to me. I think she was kind of quite lost of how to approach things. It's a bit like, you know, there is this problem that she's got inside her head, but she doesn't know at all how to talk about it, how to approach it.

I know that for some [specific intervention named], umm where it is kind of an intensive intervention from practitioners who come into the home and do the work at home with the young people, it, you know, can help sometimes.

d. Finally, the last important element about participants' ideas on interventions relate to helping that separation from the parent, which can also happen by keeping firm boundaries in the therapeutic frame, which are often difficult to keep when there are separation issues. Separation and boundaries are also interrelated with fostering contact with reality, which has limits and sometimes this is what these young people wish to avoid.

Participant 3

I kind of feel that you know, if mum is supported and if mum allows her to maybe test things and try and fail some of them. Umm and mum believes that she can survive this, that she can survive as a parent and also her daughter can survive, umm I think that's when probably this young person will be keen to trust herself a little bit more that she's got enough kind of coping mechanisms inside her to manage that external world.

Participant 1

She emails me beforehand [last session] and says, 'Look, I don't want to have a last session. Can we just pin this until I can come and see you in person?' And I think well, she didn't want the work to end. So I say, 'Look, we have agreed this date, I think we need to end. I'm very happy if at some point in the future you want to come and see me in person, to say goodbye in person, I'd be delighted to see you. But we're going to end on video on the date we agreed. So she accepts that.

Participant 4

I think it was good that quite fine balance between mum and dad in a way, about the being present and kind of persevering and waiting for him to be ready to come back or tell me certain things. And kind of bringing a bit of a limit, you know, like with the consequences of his action, you know, we can't keep offering appointments that are not attended. If you don't get back to me by this time, I'm gonna have to, we're gonna have to close the file.

Participant 1

So there's a point later on where I say to A 'look, I think it'd be much better if we could meet by video, rather than just on the phone. I think this would be helpful in terms of facing the world a bit. Even if it's only me'. And so, somewhat reluctantly, we have video calls.

Participant 4

I mean it's quite a tricky thing to work with older adolescents because you need to… they are young adults and they have the right to have their own space. But the same time, he is someone that is in his own world. And there's something about that being replicated in the therapy.

Subtheme 5b. A gradual recovery

This final subtheme relates to participants' observation of some signs of recovery, whether very small improvements in opening up or going back into the world. Through consistent therapy and sometimes different approaches from other family members, some developments could be noted:

Participant 4

It's ongoing and things have changed a bit actually lately. Perhaps this is my fantasy, but like we stopped using masks in the room [not required by covid rules anymore], we can actually kind of see each other's faces. He's been able to open up a bit more and talk about his struggles with relationships […].

At the moment, for example he describes how dad might react when he's feeling low and doesn't want to talk, and dad says 'well, whenever you are ready, we are

downstairs, if you want to talk'. And he may find himself more likely to go and talk to them when dad does that.

Participant 1

By the end of the therapy, she was more reconciled to how she was, and less persecutory of herself. […] By the end, A was looking at me more directly and I could see her face.

[After ultimatum by mother's partner to do something or leave the house] What transpires is that she just leaves, walks out the house. Mother's not there. She goes to stay with some friends in London for a day or two. And then she discovers that there's some joy in being out. She talks about walking around the local parks and enjoying it. So the fear of being seen has gone, I mean I think she's still a bit wary, but nevertheless, she's out.

I think I saw him for about three months here. And then what happened was the maternal grandfather took him in and he goes to school straightaway. And then he did pretty well.

Some important changes were also apparent to participants when the young people were ambitious and wanted to do well, feeling the loss of what they were missing while unwell, and were capable of using the therapeutic help offered to re-join the world:

Participant 2

The girl I described uh, particularly when I was seeing her by herself, she was, you know, able to verbalize her wish to go back into school and think about the difficulties she had before and what she thinks it would be difficult and you know and a wish to go further with her education. So she was in touch with what she was missing.

I think it's just getting to know this girl and how, you know, important it was for her to break through almost this.... uh... I imagine you know the trauma like a 'wall'. She had to break through a little bit to be able to just sit those exams because she had she had so much information. She had already decided what she wanted to do afterwards […].

Participant 3

And I think you know that there was a part of her that actually is quite ambitious and wants to do well and wants to succeed and wants to kind of feel capable

And she went to school towards the end, kind of like, I think two months prior to GCSEs, she started going back to school. Umm. And now she's in the sixth form. Uh, I think she's accessing at this point she's accessing private psychological help.

4. Discussion

This study explored child and adolescent psychotherapists' understanding and experiences of working with socially withdrawn young people in two London mental health settings, and their interviews have generated very rich and interesting themes. The detailed material from the interview data could be discussed more extensively, however the space here is limited. I will discuss all five main themes and their subthemes to give justice to the breadth of aspects that emerged in relation to this multi-layered phenomenon, from issues of definition and identification to interventions. However, I will focus in greater detail on the sections 'contributing factors' and 'a retreat from life' as they yielded very stimulating reflections from participants' lived experiences on the nature of this phenomenon centring around the conditions for growth and separateness, with very interesting links to the literature. I will also discuss the limited results found in relation to the emotional impact. Another important aspect relates to the parameters I used to explore the concept of social withdrawal with the participants. Early on in the project, I faced the dilemma of how stringently to define this concept and whether to adhere to the strictest definitions of hikikomori in Japanese new diagnostic frameworks, for example it lasting six months or more, or involving different degrees of severity based on how often the individual leaves the family home. However, the aim of this project was to be explorative of a new phenomenon that currently has not been researched sufficiently in a UK context. Therefore, I chose to allow for greater breadth in the way participants could consider a young person to be socially withdrawn and the age of the patients described, even though there was a clear understanding that the main focus would be on adolescents and young adults. This flexibility allowed for interesting findings that would otherwise not have been possible, such as the discovery of the importance of noticing signs when the condition is not yet extreme (i.e. young people with social anxiety before becoming

school refusers) and younger children being affected as well as adolescents, as it is explored in the section below.

1. The what and the who

School Refusal

The aspect that emerged the most when the participants described the problem was the young people's refusal to go to school, or university, or embark in any form of training or work when they are older. School refusal seemed to also be the trigger point for people around the young person to consider the existence of a problem and bring it to the attention of professionals, for example through referrals to mental health settings.

Keeping the definition of social withdrawal more open allowed to find interesting facts about young people described by participants who were not initially at an extreme stage of isolation, and yet showed worrying signs of potentially developing a more deep-seated engrained problem. This is especially relevant in light of participants observing an escalation of the withdrawal from school anxiety initially, to school refusal and cutting off from friends later on. Therefore, there could be unintended consequences for being in a prolonged state of isolation and social anxiety, which could affect mental health and opportunities to develop interpersonal skills and resilience for later life. The findings clearly highlight the importance of noticing the earlier signs of those who struggle to engage in school before they become school refusers.

The more entrenched phenomenon of NEET ('not in employment, education, or training') was indeed found in the literature to be growing in Asian and European countries (Carli et al., 2014). Although the phenomenon of NEET differs from Hikikomori and Social Withdrawal,

some sociologists have considered it another social issue of young people (Furlong, 2008) and other researchers have considered these phenomena to share potential causes and overlapping aspects (Bowker et al., 2019), which require further investigation across worldwide societies. Some researchers suggest that withdrawing during adolescence, where interpersonal relationships are formed, has the risk of leading to future problems, such as becoming NEET later on (Lee et al., 2013; Yong & Nomura, 2019).

Research in the literature also points to self-seclusion being an increasing habit in Western young people and it warns against underestimating Hikikomori being present in European countries (Caputo, 2020; Loscalzo et al., 2016). In fact, studies have identified some initial interventions being set up in public and private services in Italy, where adolescents show signs of high social anxiety and reduced engagement with the outside world and their condition might not be identified correctly (Ranieri, 2015).

Male adolescents and younger children

Regarding the affected population, participants have mainly discussed their adolescent patients, as part of the study design and as compatible with the literature (De Luca, 2017; Tamaki & Angles, 2013). Findings in this study, however, also show that younger children are already affected by social withdrawal, particularly when they are at the point of transitioning from primary to secondary school, and therefore just before or around the time of puberty hitting. This again reveals the benefits of not limiting the parameters of social withdrawal to its associated specific age, as this interesting finding could be discovered and explored. Coren (1997), in his psychoanalytically based view of adolescence, argues that earlier phases of development are reworked during different stages of adolescence. He points to the process of self-preoccupation, often in relation to the realisation of one's separateness and one's changing body, that occurs in early adolescence, leaving space for other phases

being reworked in later adolescence. However, this marks the very beginning of adolescence as a period of great confusion, where conflicted wishes need to be negotiated. Events such as the onset of puberty and the transition from the more nurturing environment of primary schools to secondary ones can exacerbate the sense of instability and self-preoccupation. Moreover, researchers Gazelle and Rudolph (2004) found in their study a possible line of continuity in social withdrawal between childhood and adolescence, where it may persist into adolescence when experienced in childhood, however it may also recover if peer relationships improve.

Furthermore, psychoanalytically oriented authors, such as Waddell (2018), also speak of the worlds that young people inhabit now as rapidly changing and exacerbating the emotional disturbance that already exists in adolescence. She argues that young people go through a separation crisis involving significant mourning for their lost childhood, certainties and dependency, during very troubled times, politically, socially, ecologically and psychologically. Following this argument, the younger age observed by participants might be partly explained by the modern rapidly changing external environment affecting young people at an even younger age. If the world is perceived as unstable and troublesome by children and parents, there will be greater anticipatory anxiety about growth and changes within oneself. Another related aspect might include means of communication changing in the contemporary world, with the potential consequence of children's increased interactions in the virtual world and possibly early access to adolescent or adult content through virtual means. Participants, in fact, mentioned young people's access to the internet, especially one who described in detail a young person spending all their time on the computer. This converges with the literature pointing to a shift from direct communication that occurred in a mutual physical space to increasingly indirect virtual and physically isolating one (Kato et al., 2018).

2. Contributing factors

Parental difficulties

Parental difficulties were one of three main factors that emerged from the data in relation to what the participants experienced as possibly being a contributor to the manifestation of Social Withdrawal in the young people they worked with. Within the large area of parental difficulties, different aspects emerged, including mental health difficulties in the parents, intergenerational trauma, and issues of boundaries and separation between parents and their children. These results converge with Li and Wong's (2015) findings where the first two contributing factors for Social Withdrawal were issues of dependence and family factors.

The present findings suggest that parental mental health issues were particularly pronounced, sometimes influenced by intergenerational trauma, and sometimes resulting in abuse or neglect of the young people themselves. Other studies within the aforementioned review indeed also identified factors such as broken families (Chong & Chan, 2012), and parenting and family dynamics that are dysfunctional (Chan & Lo, 2016; Heinze & Thomas, 2014; Suwa & Suzuki, 2013; Suwa et al., 2003).

This important aspect of parental mental health can be understood in the context of the psychoanalytic founding idea of the function of containment, developed by Bion (1985), who stressed the need for a secure link with the maternal object for the individual to venture out into the world equipped with resources and a sense of trust. He describes situations where the maternal containment fails and the mother cannot take in the child's projections and make sense of them. This creates a rupture in the link with her as a good object and it impairs the child's capacity to communicate their needs. When these failures happen consistently, the

individual struggles to develop an internal capacity to contain painful emotions and the challenges of life and growth. Participants, in fact, described at length how parents with their own mental health difficulties struggled to contain their children's anxieties and, even more worryingly, often projected their own anxieties onto them.

Another aspect under the broad umbrella of parental difficulties concerns issues of separation and boundaries. Participants conveyed their thoughts about young people having an enmeshed relationship with their mothers, parents being overprotective and sometimes filtering the outside world for them, with the consequence of observing the lack of a separate identity in those young people. This is again reflected in Li and Wong's (2015) review, where the other main contributing factors related to dependence, such as overdependence on parental figures (Borovoy, 2008; Suwa et al., 2003) or a retreat from the burdens of interdependence in society (Toivonen et al., 2011). Moreover, a longitudinal study (Choi et al., 2020) highlighted particularly how parents' 'laissez-faire' attitudes in raising their children, without imposing any boundaries, or parents' over-protective behaviours, not allowing for space and separation, led to social withdrawal later on in the children's lives.

Added extra pressures

Another major factor experienced by participants as facilitating the young people's trajectory towards withdrawal was considered to be any added extra pressures on an already complex adolescent journey, especially in the cases of young people lacking a stable confident base to face the changes of growth and the journey toward greater independence and individuation. Indeed, most participants shared their ideas about exam-related stress having a strong impact on young people's wish to withdraw. Additionally, one participant highlighted a young person's move to a smaller area very far from where she grew up. On this point, Waddell (2018) argues that, as adolescents are caught between lost childhood and unrealised

adulthood, being torn between opposite wishes, external events that would ordinarily be experienced as traumatic can be even more destabilising in this phase of life.

These aspects are reflected in the literature, for example in an interesting study by McCullagh (2020), who analysed the narratives of withdrawn young people aged 16 or over. Findings show that longer-term tendencies are influenced by specific incidents, such as 'Catalytic Events' which were associated with significant changes in the young people's experiences, such as starting new educational settings, confrontations in the social context of the classroom, or moving home.

Interestingly, Ranieri (2018) postulates, related to this aspect, how adolescents can experience withdrawal as an attempt to regain control over their environment when they are going through a transitional phase. However, he warns again the risk that it soon becomes a trap for the young person who becomes imprisoned in a complex psychic mechanism that hinders further growth and independence.

Furthermore, even greater societal forces may create additional pressures that impede a wish for young people of today to be part of a social world out there, engaged and seen, where they may or may not feel that they fit in. For example, a participant highlighted how most of their withdrawn patients were second-generation immigrants. Is there a difficulty for these adolescents in fully connecting with a social world when their cultural identity might not be as processed and as solid? Do children of immigrants face any cultural loss that may then affect their sense of a secure and stable base? What are some of the mind sets of parents who have immigrated to this country, and could they have an impact on their children's view of their realities and their futures? Sarchione and colleagues (2015), in a wider outlook of the link between this condition and society, suggest that several social and cultural global aspects may explain the increase of hikikomori cases in Western realities, including high

unemployment/underemployment rates, individualism, the crisis of traditional values, and the increase of communication technologies. They describe this state of things as a ‘modern type depression’, or ‘social anorexia’.

The pandemic

A final major contributing factor that also pertains to the realm of worldwide issues was felt by all participants to be the impact of the Covid-19 pandemic, and particularly the lockdowns and social restrictions. Some participants interestingly noticed how, in the eyes of the adolescents, the pandemic suited them when they were already attempting to hide from the world.

Indeed, psychoanalytic literature on adolescents reveals interesting ideas about ordinary adolescents constantly shifting between venturing out further away from their parents, trying to find their identities in relation to others outside the family, and the coexistent fears and ambivalence at doing so, leading to the opposite movement of retreating back into a younger version of themselves (Hoxter, 1964). Indeed, Waddell argues for a distinction between “classic narcissistic mechanisms” (2018, p.157) and the narcissistic projection and splitting that are part of ordinary adolescent exploration. However, these shifts refer to more organic and spontaneous phases of adolescent development, where confusion and conflicted wishes need to be negotiated at different times in different ways (Coren, 1997).

The pandemic-related lockdowns, however, created an enforced form of retreat from social contact. As much as lockdown may have felt like a relief to some adolescents initially, as it allowed hiding back into the parental world, its prolonged and forced nature may have then caused longer-term suffering and loss of previous identities and skills. All participants, in

fact, reported cases where the forced withdrawal and isolation imposed by the lockdowns had a profound negative effect on young people with previous social difficulties. Participants observed how these young people remained in a state of withdrawal even after the restrictions were lifted.

These results converge with a multitude of studies in the literature, for example a systematic review of 21 studies that indicated that social isolation and distancing could be a risk factor in mental health deterioration (Stavridou et al., 2020). There are studies that found that limited socialising affected everyday life functioning (Velez et al., 2022), that home confinement increased anxiety symptoms (Hawes et al., 2022), and that adolescents at risk of psychological problems or vulnerable in any way before the pandemic were mostly negatively affected, experiencing a worsening in their mental health, such as depressive symptoms, impaired relationships with others, and loneliness (Branje & Morris, 2021; Kiss et al., 2022; Li et al., 2022; Spettigue et al., 2021; van Loon et al., 2021).

Overall, an interesting aspect emerged from the study on this topic. As much as all participants mentioned the pandemic as having been an important factor at different points in their interviews, they did so in a more matter-of-fact way and rarely explored this aspect further nor did they connect it to any emotional content, either in themselves or in the young people they described. Upon reflection, the role of the pandemic may have been an aspect of the participants' work with these young people that may have been painful and complicated to explore in more depth. This made me wonder whether the participants were still in a numb state of mind, since the pandemic and its impact are still very recent. Were clinicians in this study, as well as everyone else, deeply affected by the pandemic? Indeed, the lockdowns will have affected the participants' own lives and work to some extent. Their capacity to maintain

links with their own support structures, setting for clinical practice, and professional networks in the clinics will have been put to the test during that time. This made me wonder whether the experience is still too recent to really fully reflect on it with emotion rather than just through words.

Furthermore, working with young people so capable of undermining communication links and the power of one's physical presence, during a phase of considerable external pressure on those very mechanisms, might have had an emotional impact that could somewhat be defended against and be too painful to delve in more deeply.

3. A retreat from life

Between a wish to connect and cutting off: a denial of dependence

Furuhashia and Bacquéb (2020), following their analysis of their clinical practice with around 370 cases of Japanese students, make a distinction between the presence and the absence of conflict in Hikikomori patients, with some expressing their suffering for their condition and some not showing any awareness of it. What emerged in this study from participants' lived experiences of working with these young people was a great suffering and ambivalence between the wish to go back to life and the wish to continue cutting off from it. This was evident in their reports of their patients constantly shifting between their wish, and often their attempt, to go back to school and then retreat again with a renewed intent to try again.

Moreover, participants found that even when the young people managed to be in school, their struggles with peers were what often precipitated another withdrawal phase. What emerged particularly were aspects of social fatigue and feelings of competition in relation to peers.

There is therefore a marked difficulty in coping in a school environment where peer relationships are paramount. Hoxter (1964) indeed highlighted adolescence as a phase where the peer group begins to have substantial influence over young people, as they move gradually further from their parental primary objects. This was also found in studies, for example when Choi and colleagues (2020) found that constant peer refusal can become internalised, decrease confidence, and can result in social withdrawal.

Therefore, these young people may wish to engage with the social world but they can't tolerate the conflict necessary to do so, finding themselves at an impasse. Mohr (2021) indeed argues that the withdrawal state itself can be seen as creating a boundary between the individual and whoever the individual is withdrawing from. However, in other instances, it is the lack of a boundary that seems significant. The conflicted and paradoxical nature of this condition was also highlighted by Caputo's (2020) study of hikikomori youths' own autobiographical online entries, where he found the contrast between a retreat into a virtual space and poor autonomy to face competitive situations and yet a wish for independence. He also discovered a refusal for intimacy and yet a suffering in not forming bonds with others.

The participants in this study further thought of the young people attempting to retreat back into a state of being where there are no conflictual, effortful, painful and separate aspects of life. One participant explicitly talked about 'a refusal to grow up' in noticing how a young man was scared of doing well and making the next steps in life that would lead to growing up and separating. There might be indeed also a deeper aspect at play than the tormented ambivalence about venturing out and tolerating intricate relationships. There might be an attempt at eliminating those complex and conflicted emotional processes involved in acknowledging one's dependence while still managing to separate, processing the loss of

childhood, and developing into adulthood. Caputo (2020) suggests that the deep suffering in facing reality might be averted through an identification with an ideal and omnipotent infantile world. Indeed, the participants in Mohr's study (2021) saw in withdrawn young people a denial of the need for others, which was reflected in the participants' experiences when they described their very existence being denied by their patient or when they struggled to keep their patient alive in their own minds.

This form of withdrawal from the world is compatible with the important psychoanalytic concept of 'psychic retreats', coined by Steiner (2003), who argued that certain individuals struggle to accept a degree of separateness from important caregivers and therefore, through that separate space, to become aware of their dependency needs. This concept involves the difficulty in tolerating this painful and vulnerable position which can lead some individuals to turn away from relationships all together. It contains, however, the consequent paradox of not finding actual independence through awareness and growth, but ending up in a position of pseudo self-sufficiency marked by utter omnipotent dependence. In fact, all participants found that the young people they saw retreated into their bedrooms in their family homes, often avoiding their family members, but de facto were ever present at home and depended a great deal on their parental figures for sustenance, shelter, and by being a constant source of worry in their minds. This mechanism is described by several authors as the basis for the formation of narcissistic structures in the internal world (Joseph, 1982; Rosenfeld, 2008; Steiner, 2003).

Collapsed space for growth

One participant powerfully compared these young people's withdrawal to an attempt go back into the mother's womb. In the womb, indeed, all needs are met automatically, without

having to be aware of needing them, without needing to ask and reach the other across a gap. This again can be understood in the context of theories on narcissistic structures, which are considered to be a defence against unresolved conflicts in the very early stages of life, where the capacity to depend on a reliable containing other and the gradual process of separation are negotiated (Steiner, 2003).

Mohr (2021) indeed found that the withdrawn adolescents described by clinicians in her study, all struggled with issues related to the passing of time and boundaries, which are paramount processes for the capacity for growth. Therapists in the study noticed a lack of the sense of time passing and their patients wanting everything to stay still, no movement, nothing to change. They also experienced a lack of change and at times wondered about their patient's unconscious wish to merge with them.

Furuhashia and Bacquéb (2020) further hypothesised in their study that there are cases where the mother and child have formed a fusional preconscious relationship and these cases are often marked by the lack of paternal agency. They suggest the possibilities that the father is unable to compensate for the mother's psychic state (schizophrenic or depressed) or that the mother becomes omnipotent and idealised. The withdrawn individual therefore creates a 'nest' with surrogates of the ever-present mother, such as the internet or affective reminders. This is very interesting considering that participants spoke about mainly mothers being enmeshed with their children, with fathers mostly being absent or, when present, abusive. On the contrary, the participant who spoke about one father being an available and positive parental figure, also discussed how in this case it was father who managed to encourage his son to come out of his bedroom through a present and yet not overpowering stance. The young person also found his approach helpful. There is therefore a lot to be discovered about the role of fathers and mothers for young people with these difficulties.

The infant's relationship to the mother and father also relates to the important psychoanalytic concept of Oedipal dynamics, particularly the move from a dual baby-mother relationship to a triangular space, where there is a wider space for individuation, creativity and growth (Britton, 1989). This move necessitates the relinquishing of the idea of sole and permanent possession of the mother, which creates a profound sense of loss and requires mourning, something that the participants described as a struggle for their patients. They depicted, for example, adolescents needing to be perceived as younger, less capable and in need of looking after by their mothers.

One participant also observed how the presence of other family members, such as the father and siblings, in his relationship with his mother, was marked by envy, collapsing the possibility for a triangular space where other relationships are allowed and where there is the possibility of observing and in turn being observed and thought about, which creates the basis for a stable secure world (Britton, 1989). The data shows participants' reflections on the consequences of their patients' inability to accept this psychic reality, which relate to psychic growth being impaired and oedipal illusions being formed, evoking a constant feeling of unreality and a pervasive sense of unfulfillment in relationships and projects in life (Britton, 1989).

The impairment in accepting reality and engaging in psychic growth that was observed in the young people in this study, is also what hinders the transition to the outside world, perceived to be uninteresting or too overwhelming. Indeed, the complex transition in early life from the maternal to the external world is described by Winnicott (1953) as very painful and requiring a transitional phase or object. Ranieri (2018) finds in his study a relevant distinction between daydream fantasies and infantile play belonging to the transitional area, from those that impede development and trap the young person in a claustrophobic space. The retreat

becomes suffocating and it nurtures the establishment of a pathological personality organisation.

Withdrawing from life

The data further identifies another feature of this theme of a retreat from life, where the ambivalence, conflicts, sufferings and early disrupted mechanisms so far described, give rise to more extreme versions of withdrawal, marked by a wish for anonymity, invisibility and almost non-existence. One participant vividly describes a young person's clear attempt at not being seen, walking slightly hunched, dressed in black and with hair covering the face. The concept of 'seeing and being seen' and the related aspect of self-consciousness, are central aspects of narcissism and are elaborated by Steiner (2006), who argues that feeling exposed to another's gaze means tolerating a degree of separateness and it makes the individual vulnerable to humiliation, whereas a narcissistic organisation makes him feel hidden and protected.

Furuhashia and Bacquéb (2020) further argue that hikikomori people in a narcissistic identification seem to be stuck in a position where they identify not only with a socially dead object, wanting society to forget them, but also to keep gazing at society, not managing to forget society. Their state of painful scrutiny of society is also highlighted in a study by McCullagh (2020), in which young people aged 16 or over who had experiences of social withdrawal revealed their awareness of the outside world, of change, and of the continuity across their earlier selves, continuing selves, withdrawn selves and future selves, with the accompanied condition of anxiety.

All participants described examples of certain young people going to the extreme of wishing, and at times attempting, to withdraw from life itself, through self-harm, suicidal ideation, or an extreme passivity in doing what is necessary to remain alive. These aspects suggest the presence of a destructive type of narcissism, conceptualised by Rosenfeld (2008), who argued that in the narcissistic person there is an apparent indifference towards external objects and the world. Joseph (1982) goes as far as thinking of the deadliness in certain individuals as an 'addiction to near-death' (Joseph, 1982), for example when they are getting increasingly absorbed into hopelessness and display behaviours such as drinking, poor sleep, overworking, avoiding eating properly or cutting off from relationships. She argues that these individuals become absorbed in a form of mental activity where they go over and over about their happenings and failures in a self-accusatory or accusatory way, getting stuck in the grip of a part of the self which imprisons them, even if they may see life outside their cavern. These are therefore psychic mechanisms that are much more serious clinically and more difficult to shift.

4. An entrenched problem

A very important theme emerged from the participants' sharing of their own experiences of clinical work with the young people, and what they have observed in the network around the adolescents, during the course of their work. The experiences shared suggest the level of complexity of treating a problem that easily becomes entrenched, due to the nature of social withdrawal itself and perhaps due to other obstacles in the wider social worlds the young people, their families and the professionals find themselves in.

<u>The emotional impact</u>

First of all, the strong emotions evoked in the participants provided a sense of the painfulness and difficulty of relating to young people presenting with this problem, their families and the network. Participants shared experiencing feelings of concern, anxiety, despair, and hopelessness. The way in which they described their patients shifting between attendance and some opening up, to then cut off again, even when present in the sessions, is interesting in light of the concepts of "excursions", which are tantalising digressions, and “enclaves”, where there is over-closeness, introduced by Edna O'Shaughnessy to refer to modes of relating aimed at avoiding facing reality and any real emotional engagement (1992, pp. 604-605). These findings are extremely compatible with the interviewed therapists in Mohr’s study (2021) who also reported experiencing an intense sense of hopelessness and stuckness in the face of the repetitiveness and non-movement in their work. They also shared how this led to doubting themselves and their work.

Moreover, therapists in this study discussed the controlling and stuck behaviours of the withdrawn young people, for example feeling that there was some intentionality on their part at keeping the therapist in a certain position of not being able to pose questions or challenges. These dynamics provoked anger in the professionals, and in parallel in the family members at home who experienced a determined passivity in the young person spending hours shut in the bedroom. Participants’ feeling of being controlled and paralysed at times, compounded with strong feelings of anger, anxiety or hopelessness, when the young people themeselves did not show any signs of having these feelings, links with the concept of projective identification (Bion, 1970; Segal, 1975). Could these young people make use of projective identification to expel their own unbearable feelings of powerlessness, anger and anxiety into the object, and thus keep a unconscious tie with it to avoid separation (Segal, 1975)? Is it possible, however, that these adolescents established a form contact with the therapists in that way, making them

feel like they felt and how unbearable it was, therefore unconsciously communicating a wish for the therapists to find a solution (Bion, 1970)? These remain unresolved questions to consider clinically.

Adam (2018) reflects on the world that young people retreat into as one where differences are denied and there is absolute control over the object. He conceptualises this as a retreat from reality that is very restrictive for spontaneous creative life and the risk-taking necessary for real relationships. In fact, during their course of clinical work with their patients, participants found the adolescents incredibly inaccessible and always wanting to remain in their static position. Participants indeed described their patients' narratives as often boring and lacking lively details that put them in touch with those realities and the feelings they may have about them. Steiner (1982) interestingly refers to clinical cases where patients present with extreme deadliness and links their destructive tendencies with the death instinct. Not only emotional contact with the participants felt difficult to establish when the young people were in a deadly unavailable inaccessible state, but participants also noticed their lack of touch with their own realities and internal worlds. Indeed, Money-Kyrle talked about the inability to acknolwedge and accept the "facts of life", namely "one's dependence on internal and external objects, generational differences, the creativity of the parental couple, and finally the inevitability of time and ultimately of death" (1971, pp. 103-106). Steiner (2003) further talks about being in an in-between state where reality is not completely disavowed, as the young people remain somewhat aware of it, but it is not fully accepted either, and idealised and persecutory aspect of the self and the objects are not integrated to form a realistic view of life as imperfect and contradictory, but are kept apart in a mechanism that keeps patients in a phantasy world, unable to face life as it is.

However, a striking aspect of the data discussed was that, although participants shared some of their own feelings accompanying their experiences, as discussed above, they did so much less than the emphasis they put on their reflections on young people's presentations, their family histories, the factors contributing to their withdrawal, treatment choices, and their conceptualisations of what dynamics might be at play within this phenomenon. Participants talked about their feelings of stuckness and helplessness but remained somewhat detached from conveying their painful lived experiences with these young people. Perhaps this is also a powerful and effective indication of the painfulness of the emotional impact withdrawn young people can have on others. Hard-to-reach, inaccessible, and sometimes unwilling to be helped young people may put a strain on clinicians apt at communicating, establishing emotional contact and helping others. Was there perhaps a sense of despair in their contact with these adolescents that may be an aspect more difficult to explore in depth? This was not necessarily part of participants' opinions, as they often thought about ways forward in their work, however I wonder if it may have been present in their clinical experience of these young patients.

In relation to the possibility of a defence agaist despair, I also wonder about the role of shame. Furuhashia and Bacquéb (2020) identified the risk of important intermediaries between the individual and society, mostly the family and school, at times hiding or minimising the young person's inability to attend or leave the house, due to the difficult feeling of 'shame'. Perhaps this feeling can at times be felt by therapists too in relation to this patient group. In the current climate in clinical settings, there is a lack of resources for attempting long and complex therapeutic work that may not produce final results. Is it possible that therapists may feel shame for using their expertise, knowledge, time and precious resources and still not always achieving the desired outcomes? Is there also a place

for projective identification (Bion, 1970) where part of this complex emotion might be reflecting a feeling in the patient group as well?

A final consideration in relation to the role of shame is my awareness of my position as a trainee researcher. I recognise and am grateful for more senior clinicians' willingness to share their experiences with me. However, I wonder about their wish to help and be educative in relation to a trainee researcher and I am left wondering whether my position may have had an impact on their readiness to open up about something that can be as personal and powerful as their countertransference.

Barriers to recovery

Barriers at a wider level were also identified by participants as making this phenomenon very entrenched. Participants particularly shared the difficulties of working with these young people at risk of going under the radar of services, falling through the gaps, with the consequence of reaching their attention when the problem is already well established and engrained. The limited resources and capacity of CAMHS services were discussed by participants, in line with Allison (2014)'s study which also highlights the impact of socio-cultural influences, such as lack of support structures, reduced social development and limited economic options on this complex phenomenon. Indeed, child and adolescent psychotherapists in this study highlighted the need for greater resources across services and communities, and particularly more understanding and nurturing environments in secondary schools. Another study based in Finland (Husu & Välimäki, 2017) also reveals hikikomori people's own experiences of society as lacking resources and demanding, including in educational settings and social networks, suggesting the need for interventions at a political and societal level.

The literature still maintains a debate as to whether this is a clinical and social issue, which complicates matters even more and may explain the different layers of complexity that emerged from the participants' accounts. Pozza and colleagues (2019) identified both threads in their systematic review, researchers considering it a clinical issue and those supporting the idea of cultural aspects being at its core. Todd, for example, considers it a form of national existential angst that leads young people to 'retiring from their society into the womb of their rooms' (2011, p. 141).

5. The road to recovery

Interventions

The experience of what interventions have been implemented and what has helped in the path to recovery, are aspects shared by the participants of this study. The findings suggest that social needs are intricately interrelated with psychological ones, often creating the need to address both at some point and that the length and multitude of interventions required for this condition are considerable. All participants, in fact, discussed in detail what a very long process it was to even begin to engage the young person and to gradually build up the work to conduct regular therapy. Participants also highlighted the need to address other aspects first, such as mood deterioration, negotiating access to education through the networks, engaging the parents and even having parent-child sessions before individual therapy could take place.

Indeed, Ranieri (2015) argues that a single approach is not sufficient and a combination of different educational and clinical interventions are needed as part of a network to nurture resources in the family, the social context and the individual. Li and Wong (2015), moreover, identified different types of socially withdrawn young people, displaying different levels of

withdrawal, and therefore benefitting from slightly different approaches. They argue that for the most withdrawn individuals, intensive individual psychotherapy, perhaps with the addition of family therapy, are needed to work on the gaps in development and the extent of the emotional distress. They suggest support groups, social activities and educational programmes for other types of withdrawn youths. However, whatever the initial causes for the withdrawal are, they identified prolonged withdrawal as causing deterioration and worsening in interpersonal skills, in turn affecting mental health, therefore all types might require a psychological intervention to foster containment and anxiety release as well as a social one.

Involving the parents was something that was particularly highlighted as important in the participants' experiences of clinical work on this topic. Parents, indeed, are often the ones that participants engaged with when the young person was difficult to access, and they are essential in helping in the recovery process and they are the primary objects the young people are in external and internal relationships with. All participants stressed the importance of keeping the parents involved and working alongside each other to support the young person as a team. Furuhashia and Bacquéb (2020) also found in their research that parent involvement was a crucial factor for the possibility of recovery for the young people. The researchers interestingly argue that the relationship between the adolescent and their parents, could mirror that between the adolescent and society. In cases where there is acknowledgement and engagement with the problem in both the young person and the parents, there is a higher motivation to engage in treatment and make use of it, whereas other cases are marked by avoidance and refusal to face the situation, which continues to remain unchanged.

Flexibility in one's approach was also part of the participants' experiences of engaging withdrawn young people, who are extremely difficult to establish contact with. The findings of this study indeed show how much the child and adolescent psychotherapists worked beyond their normal scope to find a way of meeting these young people, for example by going to their family homes or trying many different methods of communication. This converges with research showing the challenges of therapy attendance for these young people. Interestingly, a study shows the low likelihood of actively withdrawing people to attend in person, compared to those on a recovery path already (Imai et al., 2020). However, the study also found that once attendance became established it lasted over time. Mohr (2021), who highlights in her findings the presence of a fear of contact in these adolescents, interestingly reflects on this having an impact on the frame of the therapy, such as when offering phone sessions. However, she suggests how the change in frame was at times necessary, when it was the only way the young person could bear therapeutic contact.

A final element related to boundaries and fostering contact with reality in their approaches. Indeed, participants reported their attempts to foster greater contact with reality by balancing the establishment of boundaries with understanding and empathy. One participant talked about the positive effect of persevering and waiting reliably for the young person to be ready, alongside being clear about the consequences of their actions and putting some boundaries, for example that continuing not to attend appointments would result in therapy stopping. Another participant spoke about the gradual but firm successful encouragement to move from telephone to video sessions to start facing the world a little, even if just the therapist.

The concepts of flexibility and boundaries may at first appear contradictory, whereas they are in fact interconnected with this patient group. Indeed, participants highlighted the need for

flexibility mainly when talking about the initial stages of treatment and underlined the importance of boundaries when talking about well established psychotherapy treatments. Flexibility may show to these young people a willingness to reach them and understand their deep-rooted anxieties. Boundaries are later needed not to collude with a problematic situation. However, what appeared key in the participants' accounts was the importance of introducing boundaries gradually and only when a solid therapeutic space is established. This relates to the transitional phase or object concpetualised by Winnicott (1953), where the illusion of a perpetual maternal presence is to decrease only gradually, to facilitate the movement toward the external world.

Ranieri (2018) emphasises the possibility and hope for human contact through the crucial presence of the therapist. In fact, he argues that the role of the therapist is to be capable of receiving the patient's projections and foster the possibility of dependence on a good object that can withstand attacks, be separate, and have a difference of opinion. The therapist can become a reliable, authentic, vital but separate presence that is so important to offer as an alternative to the false protection proposed by the narcissistic pathological organisation.

A gradual recovery

Finally, participants shared that some young people recovered or partially recovered through the course of their interventions. The young people that participants felt recovered, at least to some extent, mostly engaged in the therapy and expressed the loss of what they were missing and their longing for it. Others were helped by a change of environment that supported their wellbeing, for example, the arrangement through the network of suitable conditions for returning to education in a manageable way. Participants therefore described moments such as when a young person returns to school and manages to sit exams.

Furuhashia and Bacquéb (2020) argued that the way the young person relates to their own withdrawal, how they feel, how they communicate about it, what activities they engaged with during, are all factors that influence the effectiveness of psychodynamic treatment on them and the possibility for their recovery. Indeed, they suggest that for the patient's social prognosis, feeling conflicted, involving the parents in the treatment, and expressing their emotions are all factors conducive to treatment as they reflect the relationship between the patient and society.

One participant also movingly reported the sensations that a young person had when finally leaving the house and feeling joy at walking around. Ranieri (2018) interestingly suggests the importance of acknowledging the leap of faith required on the part of the adolescent to leave their retreat and re-discover life and vitality.

6. Limitations

Sample size

A very small number of child and adolescent psychotherapists were interviewed in this research project. Although the aim of Interpretative Phenomenological Analysis is to explore a topic in depth through a small sample size and the aim of this study was to explore this particular phenomenon through rich and detailed in-depth narratives, the sample size is too limited for the findings to be generalisable to other psychotherapists in other services. This has implications for clinical practice to be based on these findings in services across the UK. Further research with larger sample sizes is needed to establish comparable findings that can inform clinical practice across the UK.

However, the findings produced an array of interesting and complex themes. These are still relevant in giving an initial picture of current psychoanalytically-based thinking on the topic of working with socially withdrawn young people in mental health settings in the UK and they are compatible with the literature in many aspects, including the male prevalence (Pozza et al., 2019), contributing factors (Li & Wong, 2015) and long-term multiple interventions needed (Li & Wong, 2015; Ranieri, 2015).

Furthermore, despite the limitations discussed above, the sample size remains appropriate for this methodology. Other methodologies could have been used, such as grounded theory (Glaser & Holton, 2007) to develop a new theoretical model of this emerging phenomenon, or thematic analysis (Braun & Clarke, 2022b) to encompass a wide range of different themes. However, IPA was ultimately the most suited methodology to analyse a specific phenomenon with fewer participants in greater depth and detail, and to focus particularly on their lived experiences of the phenomenon (Tindall, 2009).

Research setting

The present study and its findings are important in that they are based in the UK and empirical research on the topic of youth social withdrawal in the UK is extremely limited (Dzik, 2019; McCullagh, 2020; Mohr, 2021). Research on this phenomenon is still largely based in Asian countries and is only gradually growing in Western countries.

However, the project has limitations in its representation of the UK context. Indeed, this study is specifically based in London and its specific diverse multicultural metropolitan setting is bound to being significant. Had the study taken place in other areas of the UK,

possibly more rural and less diverse, the results may well have been different. Future research is needed to capture a more diversified social context in other areas of the country.

Selection of participants

The choice of selecting psychoanalytically trained child and adolescent psychotherapists was aimed at gathering in depth ideas concerning both conscious and unconscious processes being active in this phenomenon. Moreover, due to the small sample size, similarities in relation to the discipline and training the participants belonged to, provided greater coherence and the possibility to analyse themes across participants based on equivalent theoretical premises and clinical approaches. Were this study to expand to other mental health professionals, it would have needed to include a variety of other clinicians and a much larger sample size.

However, this selection limited the study in that perspectives from other disciplines working in the same mental health settings were not heard. These would be very valuable in understanding other thoughts, experiences and approaches to the same phenomenon, especially given how findings around interventions indicate that a combination of different treatments and approaches is needed. Future research could potentially address this limitation by expanding qualitative research to other disciplines in mental health working with this phenomenon.

Relationship with the researcher

It is important to acknowledge the dynamics of the relationship between interviewee and interviewer as it has significance over the generation of data (Pietkiewicz & Smith, 2014). Indeed, three out of four participants were colleagues of the researcher in the teams in which

she worked. This will have inevitably influenced their willingness to participate in this study and how they will have responded to questions in the interviews. It will also have predictably affected how the researcher related to them during data collection and data analysis.

For example, the three participants who were colleagues of the researcher were particularly keen to give justice to their answers to the interview questions and were apologetic when the allotted time ended. These situations were mitigated by the researcher acknowledging the time limit and reassuring the participants that they had provided rich and helpful information. One participant chose to remain longer than the required time in the interview. The researcher decided to accept the extended time after establishing both their availabilities.

However, having good established relationships also meant the participants had trust in the researcher's respect and professionalism, and this resulted in openness and richness in their responses. Regarding the impact on data analysis of knowing three of the participants, the researcher use bracketing (Tufford & Newman, 2012) to account for any preconceptions of the participants in question being very conscientious, skilled clinicians, going above and beyond for their patients, especially when analysing their interventions.

Conclusion

This research project involved a very enriching immersive process, from the original idea being formed to the development and discussion of findings. It was wide encompassing of several different aspects of youth social withdrawal that were explored with the participants based on their understanding and lived experiences in their clinical practice. These areas ranged from initial definitions of the phenomenon to ideas about interventions. The main findings of this study provided an emerging picture of youth social withdrawal in the way it presents in specific London mental health settings, and it can be summarised as:

- This phenomenon affects adolescents and young adults, as predicted, but also younger children.
- It manifests itself at the point of school refusal and it is an escalation from earlier signs of school anxiety and attendance patterns.
- It needs to be thought of in the context of family dynamics and difficulties.
- It is rooted in disruptions in early psychic life in relation to separation and growth.
- There are significant barriers in helping hard to reach young people, both in the way they relate to a helping other and in terms of available resources.
- The pandemic exacerbated difficulties further by providing an experience of prolonged social isolation
- Clinical approaches involve long-term therapeutic interventions, and require a delicate balance between flexibility and boundaries.

It was particularly striking to observe the emergence of themes around the difficulties in reaching out to young people who refuse to relate and communicate, sometimes wishing to be invisible, and yet ending up being always present in the minds of those worried about them.

Mohr (2021) also argues how her study shows the tenacity of the withdrawal state and the difficulty, persistence and immense effort required to move out of such withdrawal.

The inaccessibility of these adolescents is indeed part of the complexity of this phenomenon as described by participants and it also seems to affect other forms of barriers to recovery such as the availability of adequate resources for such length treatments where the work of engagement of a young person can take a very long time and the capacity to withstand rejection and the refusal to initially use those resources is paramount.

It is interesting that an emotional barrier may have been active in the participants during the interviews as well. Indeed, participants in this study seemed to have found it harder to stay with the emotional impact of this type of patient presentation on their capacity to take in and contain certain states of mind involving refusal, rejection, lack of a will to make contact and receive help. This raises questions as to what is required of individuals tasked with helping withdrawn young people, how they can be equipped to do so, and what does society has a whole need to acknowledge to provide the space and resources required to address this emerging issue. This is compatible with Mohr's (2021) view of the need too see withdrawn young people in generic adolescent mental health settings due to therapists needing a variety of work, given the feelings of hopelessness and despair evoked in them by withdrawn youths. However, it also points to the increased need for resources to intervene when young people are at risk of dropping out of school and to provide longer-term treatments.

Overall, despite the participants clearly highlighting all the challenges and obstacles to working with this patient population, I expected a bleaker picture from their narratives. Indeed, participants always thought about a way forward in the work, considered how some

of the work they were doing helped and showed how several young people recovered from the deeper phases of their withdrawal. Perhaps this issue has the potential for becoming more defined and established in clincal practice and receive the support it requires to allow clinicians to continue the work they are doing.

The following research and clinical implications can be drawn based on the findings and limitations of this study:

Clinical and research implications

- Both a clinical and research implication relates to how school attendace and school anxiety can be potential predictors for the development of severe social withdrawal. Identifying youths in the early stages of social withdrawal can be a vital opportunity, as this study shows that there is an escalation in their withdrawal and it can become very entrenched and difficult to shift over time. What would be important to discover is how to distinguish between the early signs of this deep-seated problem and more ordinary school anxiety. Further research is necessary to throw light on what specific signs and factors might lead to eventual severe social withdrawal and how the information could be fed into educational and clinical environments. Rich qualitative findings are needed to base hypotheses on for later testing in quantitative research.
- Another clinical and research implication relates to therapeutic interventions and particularly the balance between flexibility and boundaries. In fact, this study shows how flexibility in the initial phases of the treatment is very helpful in laying the foundations for later work, and gradually introducing boundaries becomes important to foster contact with the world and not collude with a wish for timelessness and omnipotent illusions of independence. The significance of recognising the right pace

for introducing challenges and the capacity to work with difficult engagement require experience and resources. Further research on clinical interventions for this phenomenon is needed, specifically to explore added nuanced details about the balance between flexibility and boundaries, and other intervention types by different disciplines.

- A research implication relates to the finding in one participant's experience that it was mainly the children of immigrants who were affected by this problem. This finding would be important to investigate further to discover whether this is wider pattern pertaining to this condition and what specifically the factors involved might be. Is there an unprocessed loss of cultural origin affecting the secure base and solid identity that children need to venture out into the world and think of a future? Through further research an important clinical implication migth emerge.
- Another research implication relates to addressing the aspect of comorbidities and how other mental health difficulties, including developmental disorders and delays, relate to social withdrawal. These aspects cab have significant clinical implications for understanding the phenomenon and how to treat it in the UK.
- Finally, other areas of scope for further research connect with the limitations of this study, such as the need for larger sample sizes, for reseach in other areas of the UK, and for the inclusion of clinicians in different mental health disciplines.

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Appendices

Appendix A: Ethical Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
Fax: 020 7447 3837

Margherita Urani
By Email

24 May 2022

Dear Margherita,

Re: Trust Research Ethics Application

Title: Social withdrawal in young people in the eyes of Child and Adolescent Psychotherapists

Thank you for sending your response to the conditions set by the Assessor with regards to your TREC application. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

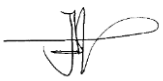
Please note that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,



Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Course Administrator

Appendix B: Trusts Ethical Approval Emails

RE: Approval for psychotherapy doctorate research project

Sheva Habel <SHabel@tavi-port.nhs.uk>
Fri 06/05/2022 12:12
To: Margherita Urani <MUrani@Tavi-Port.nhs.uk>
Cc: Geraldine Crehan <GCrehan@tavi-port.nhs.uk>

Confirmation that trainee project can be undertaken in service

Trainee: Margherita Urani

I understand that this trainee will soon be ready to start data collection for the research project they will complete during their DProf clinical training programme in Child and Adolescent Psychotherapy. The aims and protocol of this project have been described to me.

I understand that the Tavistock & Portman NHS Foundation Trust are the sponsors of this educational research project and will provide the necessary support and supervision for it to progress.

Subject to final approval by the Tavistock Research Ethics Committee, I confirm that the project as described can be undertaken in this service.

Dr Sheva Habel
Consultant Child and Adolescent Psychiatrist
AYAS Clinical Service Manager

Confirmation that trainee project can be undertaken in service

READ, Tina (BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST) <tina.read2@nhs.net>
Tue 07/06/2022 16:52

To: URANI, Margherita (BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST) <margherita.urani@nhs.net>;CARTER, Mark (BARNET, ENFIELD AND HARINGEY MENTAL HEALTH NHS TRUST) <mark.carter1@nhs.net>

Appendix C: Public Facing Documents

Recruitment email:

The Tavistock and Portman
NHS Foundation Trust

Dear all,

I am about to embark on my Doctoral Research Project as part of my Child and Adolescent Psychotherapy training. I am contacting you to see if you would be interested in taking part.

The project title is: Child and adolescent psychotherapists' views and experiences of working with young people presenting with Social Withdrawal.

I am interested in exploring child and adolescent psychotherapists' thinking and experience of working with young people (13-25 years) presenting with symptoms of social withdrawal. I am hoping this may also provide with a space to consider and reflect on what it is like to work with these adolescents and young adults and learn from this for their own practice.

I would like to invite anyone who is training or is qualified as a child and adolescent psychotherapist and has had any experience of working with socially withdrawn young people (13-25 years) to take part in an interview to discuss what it has been like. These interviews will be guided by me and will last approximately 60 minutes. They will take place within your usual place of work or remotely (if preferred).

I would very much appreciate your willingness to contribute to my project. Please find attached a participant information sheet for your information.

Please email me if you are interested in taking part and/or finding out more about it.

Best wishes,
Margherita Urani

Participant Information Sheet:

The Tavistock and Portman
NHS Foundation Trust

Participant Information Sheet

Research Project Title: Child and adolescent psychotherapists' views and experiences of working with young people presenting with Social Withdrawal

What is this project about?
This study looks to explore how child and adolescent psychotherapists think about and experience young people (aged 13-25) presenting with symptoms of social withdrawal.

Who is conducting the study?
My name is Margherita Urani. I am a trainee at the Tavistock and Portman NHS Foundation Trust going to become a Child and Adolescent Psychotherapist. This project is part of my training and is sponsored and supported by The Tavistock and Portman NHS Foundation Trust and has been through all relevant ethics approval (TREC). This course is overseen and certified by The University of Essex.

What will participating in this study involve?
You would be asked to take part in one semi-structured interview, which will last for approximately one hour. Interviews will take place either face to face or remotely via video link, based on your preference. During the interview, you will be asked to reflect on your clinical work with young people (aged 13-25 years) presenting with symptoms of social withdrawal. I will ask you about your thoughts around the phenomenon of social withdrawal and to reflect on your experiences of working with these young people, including aspects of transference and countertransference communication.

Who can take part in this study?
All participants will be expected to be child and adolescent psychotherapists either qualified or in training. All participants will be expected to have had some experience in this role of working with young people (13-25 years) who present with symptoms of social withdrawal (one case or more). These symptoms may include the following: refusing to go to school or attending only under significant pressure from the family; losing or being in the process of losing contact with friends or peers; spending the majority of their time alone; withdrawing from social contact with people external to the family; withdrawing into their homes or bedrooms.

What are the possible benefits of taking part in this project?
You may benefit from the opportunity to think about and make sense of your experience of a hard to reach and complex patient group, particularly in light of the Covid-19 pandemic and its impact on the social development on many young people. You may gain some personal satisfaction from knowing that your involvement in this project could contribute to the body of knowledge and understanding in the field of child and adolescent psychotherapy.

What will happen to the data collected?
Each interview will be recorded and transcribed verbatim. Any information from the interview about you, your work setting or your patients will be anonymised so that they cannot be identified in the study's write-up. Electronic data will be stored on a password protected computer and paper copies will be kept in a locked cabinet. All audio/video recordings will be destroyed after completion of the project.

More information on the Tavistock and Portman and GHC privacy policies can be found here: https://tavistockandportman.nhs.uk/about-us/contact-us/about-this-website/your-privacy/https://www.ghc.nhs.uk/privacy-notice/

You can also find more information on the legal framework within which your information will be processed by contacting the sponsoring Trust's Clinical Governance and Quality Manager, Irene Henderson: IHenderson@tavi-port.nhs.uk

What will happen to the results of the project?

The results of this study will be used in my Professional Doctorate thesis. It may also be used in future academic publications and presentations. I am also happy to provide a summary of the results, if you wish to receive it. Please feel free to contact me if you do.

Disclaimer

You are not obliged to take part in this study and are free to withdraw from the project for up to three weeks after the interview. Accepting the offer to participate or choosing to decline will have no impact on your assessments or learning experience at the Tavistock and Portman NHS Foundation Trust or the University of Essex.

Contact details:

Margherita Urani
Child and Adolescent Psychotherapist in Doctoral Training
Tavistock and Portman NHS Foundation Trust and University of Essex
Murani@tavi-port.nhs.uk
07900383777

Research Supervisor:
Dr Felicitas Rost
Frost@tavi-port.nhs.uk
02089382234

If you have any concerns about the conduct of this research, the researchers or any other aspect of this project, please contact the Head of Academic Governance and Quality Assurance: Beverly Roberts academicquality@tavi-port.nhs.uk

Thank you for considering taking part in this study and taking the time to read this information. If you are willing to take part in the research or have any further questions, please contact me.

Consent Form:

The Tavistock and Portman
NHS Foundation Trust

Consent Form

ProfDoc research project title: Child and adolescent psychotherapists' views and experiences of working with young people presenting with Social Withdrawal

- I_____voluntarily agree to participate in this research project. ☐
- I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw, without giving a reason, at any time up to three weeks after the completion of the interview. ☐
- I understand that the interview will be digitally recorded and transcribed as described in the participant information sheet. ☐
- I understand that the information I provide will be kept confidential, unless I or someone else is deemed to be at risk. ☐
- I understand that direct quotes from the audio recording may be used in this research study but will be made anonymous to the reader and held securely by the researcher. ☐
- I understand that it is my responsibility to anonymise any examples referring to cases I chose to discuss during the interview. ☐
- I understand that the results of this research will be published in the form of a Doctoral research thesis and that they may also be used in future academic presentations and publications. ☐

Contact details:

Researcher: Margherita Urani Email: Murani@tavi-port.nhs.uk
Supervisor: Dr Felicitas Rost Email: Frost@tavi-port.nhs.uk

Participant's Name (Printed):_____

Participant's signature:_____ Date:_____

Thank you for agreeing to take part in this study. Your contribution is very much appreciated.

Debrief letter:

The Tavistock and Portman
NHS Foundation Trust

Post-Interview Information and Debrief Letter

Dear Participant,

Thank you very much for taking part in my research project.

I'd like to remind you that all information collected during your interview will be stored securely and that any information from the interviews about you, your work setting or your patients will be anonymised so that they cannot be identified in the study's write-up. All audio/video recordings will be destroyed after completion of the project. I will hold on to your contact details so that I can let you know when the research is published, in case you'd like to read it.

If you have any further questions, my contact details and those of my research supervisor are:

Margherita Urani
Murani@tavi-port.nhs.uk
Phone: 07900383777

Dr Felicitas Rost
Frost@tavi-port.nhs.uk

If you have any concerns about the conduct of the researcher or any other aspect of this research project, please contact Beverly Roberts, Head of Academic Governance and Quality Assurance at the Tavistock and Portman NHS Foundation Trust (academicquality@tavi-port.nhs.uk).

Best wishes,
Margherita Urani

Appendix D: Interview Schedule

The Tavistock and Portman
NHS Foundation Trust

Semi-structured interview schedule for child and adolescent psychotherapists working with or who have worked with cases of Social Withdrawal

ProfDoc research project title: Child and adolescent psychotherapists' views and experiences of working with young people presenting with Social Withdrawal

Researcher: Margherita Urani

Welcome: explanation of it being a semi-structured interview lasting one hour. Remind them that they are welcome to talk freely about the topic of how they think about and have experienced Social Withdrawal in their clinical work. Explain that they can discuss specific cases (past and present) that may feel relevant and they will then be anonymised.

Characteristics of withdrawn young people

- Can you tell me a little about the young people you work with or have worked with who present with symptoms of social withdrawal? Do you have any specific examples?

Characteristics of family, school and social context

- Can you tell me a little about their families and how they usually approach the situation? Do you have any examples?
- Based on your experience, what is their school situation?
- And their social lives? What is their relationship with friends and peers?

Characteristics of the phenomenon

- Given your experience of working with these young people, what do you understand of their difficulties?
- What do you understand of the factors that lead to their withdrawal? And the warning signs?
- How do you make sense of this phenomenon?
- What has been the impact of the pandemic and the lockdowns on them?

Experience of young people with symptoms of social withdrawal

- How do you experience these young people?
- What feelings do they provoke in you whilst working with them? Do you have any specific examples?

Experience of working with this phenomenon

- What types of intervention have you offered?
- In your experience, how do these young people normally engage?
- What is their families' involvement?
- In your opinion, what are the major barriers to the work?
- And what do you think works well?
- What has been your experience of the impact of the pandemic and the lockdowns on the work?
- What support system have you had during this period?

Future

- What hopes do you have for a possible outcome of the treatment, based on your experience?
- What else do you feel is needed to work with this particular patient group?

End

- Are there any aspects of your experiences and views in relation to social withdrawal in young people that have not been covered in this interview?
- Thank you very much for helping me and giving up your time.

Appendix E: Sample of data analysis process

To show how the researcher has approached the task of analysing the data, examples from Interview 2 are given below. Initially, an extract of the Interview 2 transcript is provided on the left, with initial exploratory notes in the next column and the creation of Experiential Statements in the final column. Subsequently, a list of all Experiential Statements from Interview 2 is provided, with the following Clustering, and the formation of Personal Experiential Themes – the final themes for each interview. The same process was repeated for each interview.

Table 1. Extract of Interview 2 Transcript p. 14-15 – Exploratory notes - Experiential Statements

Interview 2 Transcript	**Exploratory notes**	**Experiential Statements**
R = researcher		
P = participant		
Introductions made and permission to record obtained before the recording started.		
[continuing]		
P: I also wonder, it was you know a single mum with the boy… and he was 14/15 years old… I also wonder about the kicking in of the adolescence forces and how there might have been a push to separate a little bit from mum. Mum was very attentive, a very good listener, and very present for this boy. But I also wonder whether something about adolescence, the need for separation kind of kicked in a little bit for him and and there might have been a, yeah, a desire to feel less dependent on mum, less enmeshed with mum, you know, and…	Adolescence and separation conflicts Wish for less enmeshment with mum, more separation Disruption of that in a safe way During this development – forced going back to mother and yet fear for life and old loss of father coming back How could he feel safe to now separate? And go through normal process, which is full of conflict and complex in its own right?	Separation processes in adolescence Conflicted wishes for more separation and less enmeshment Disruption of that process if additional pressures
R: Mmh.		

P: [Continuing her train of thought] Because he ended up staying, you know, spending the whole time in his bedroom, not wanting mum to come in. So he was almost like seeking refuge in this extreme isolation, you know.	Extreme isolation, from mother as well. Is it a way of managing the wish to separate and the inability of doing it safely as too much unresolved going on? (Loss not processed and new fears of lack of stability and reliability of the world).	Cutting off from parents Conflicted wishes for separation expressed in cutting off to avoid experiencing pain and loss of real separation
R: That's an interesting idea. The idea of a struggle to separate from a parent and doing it in a way which is in some ways removing himself from the parent… but in way where he is trapping himself at home at the same time and not actually having it [the separation].	It is a trap. Not separating, not staying close. Impossible situation.	
P: Absolutely. It's a quite destructive kind of way. Yeah. Because at that point, you know, he was quite ambitious and had done fairly well academically. And he was losing his capacity, he was losing his grades. And so the the idea of going back into school felt terrifying as though he had lost his identity of a capable, sociable boy. And then, it seemed that the safest, but in a destructive way, but the safest way of surviving was to isolate himself in almost this double isolation that he suffered, you know, before with the lockdown.	Loss of his identity as sociable capable boy Due to pandemic Can't go back to that as disrupted as it was forming.	Pandemic: Loss of identity while forming

2. List of Experiential Statements from Interview 2

Experiential Statements

School Refusal
Complex issue
Entrenched issue before help is sought
High workload
Joined up work
Multiple interventions
Adolescent girl
School Refusal
Alarm at problem set in for 3 months
Social withdrawal from peers
Adolescent boy
Pandemic impact
Change during and after pandemic
Struggles with getting out of bed
Contrast between wish to come out of withdrawal and behaviour getting worse
Depression and anxiety setting in
Childhood trauma: loss of father

Pandemic triggered previous traumatic loss
Younger child
Parental mental health difficulties
Impact on freedom to leave home and live their lives
Overprotection of parents
Parental mental health difficulties shake secure base
Base unstable and unpredictable
Adopting parental responsibility
Added developmental and external pressures test the base
Insecure base cannot withstand added pressures
Ordinary separation not possible
No freedom to let go and leave someone behind safely as developmentally appropriate
Stuck between wish for independence and utter dependence
Ordinary flow between independence and dependence during adolescence not possible
Cutting off, withdrawing, but utter dependence
Struggle to find more solid actual independence
Family difficulties greater than pandemic
Impact of mother's conflictual relationships
Caught up in a system of family dynamics
Girl ambitious and keen to do well.
Difficulty in addressing unhelpful dynamics in parents
Primary effective intervention: Network support
Primary effective intervention: Finding a priority
Primary effective intervention: Remaining focused on priority
Containing function of network meetings for family
Coming together to think and listen to each other
Parent feeling heard
Negotiating conditions that allow gradual re-integration
Individual specific mental health interventions at late stage
Specific individual intervention after initial priority attended to
Later intervention to address trauma due to parental mental health
System at a loss
Role of clinician maintaining some distance to focus on main task
Risk of being pulled into relationship dynamics at play
Need for boundaries in the approach
Need for parent to be contained
Challenges to boundaries
Pain and immense need
Intergenerational picture of trauma
What helped maintain focus: Working with others, not in isolation
What helped maintain focus: Getting in touch with loss and sadness
What helped maintain focus: Getting in touch with potential and hope
Trauma in social withdrawal – wall to break through
Contingencies, steps and options helped young person
Step by step approach for YP and parent
Paranoid-schizoid position
Splitting
Need to contain splitting by bringing people together
Need not to act out the projection of unmet need from family and system
Not feeling useless and paralysed but remaining hopeful and focused on gradual steps
Contrast between wish to get better and rejecting help
Getting worse, escalating from withdrawal from school to withdrawal from friends
Medication useful in acute crisis
Pandemic: forced loss of current life rewoke early traumatic loss
Internal - external imprisonment

When the external situation mirrors an internal one
Impossibility of recovering with only external change as internal state set in motion
Separation processes in adolescence
Conflicted wishes for more separation and less enmeshment
Disruption of that process if additional pressures
Cutting off from parent
Conflicted wishes for separation expressed in cutting off to avoid experiencing pain and loss of real separation
Pandemic: Loss of identity while forming
External-internal isolation difficult to sustain over time – it leads to more isolation
Relief only initial
Therapist concerned around risks
Acute phase helped by medication
Intervention: holding sessions for parent and child first
When more stable, individual intervention offered
Could make use of therapeutic intervention only after acute phase attended to
Difficulty in separating in treatment too
Expressing what parent cannot hear
Separation and space allow processing own feelings
No space between parental and child's feelings.
Enmeshment.
Claustrophobic internal place – no space for self
Locking self into small place
Countertransference - abandoned little boy
Profound sadness
Loneliness in parent
Loneliness underneath capable thoughtful resourceful professional parent
Pandemic: loss of usual life and support system for parent
Impact on child
Shared unspoken mental state
Pain
Sadness
Loneliness
Conflict
Losses and changes
Boy 12 years old
Parental mental health difficulties
Losses
Trauma
Social withdrawal: defensive function in the face of an unsecure base
Unpredictable unsecure base
12-year-old boy known to CAMHS since 7-8 years old
Omnipotence – illusion of no needs
Reversal of Oedipal dynamic
Enmeshment between mother and child
The role of the mother
Difficulty in separating when parent not safe
Parental ambivalence at separation
Worry and mistrust at letting go of the other
YP different without parent
Own space to express self without worry about parent's feelings
Increase in openness, capability, age-appropriateness without parent
Freedom to be competent, more independent self without parent
Whose need is it to remain in a younger position?
Conflict between self views and views from parent

Parent's projections in child to remain a child?
Fear of parental feelings in relation to growing up, separating, succeeding?
Retreat from conflict between infantile self and older self
Retreat to the womb
Avoidance of any separation and awareness of need by cutting off
Wish to recover and being in touch with loss helps treatment
Lack of touch with loss linked with deterioration
Anti-life wish
Clinical approach around three aspects at the same time: Child, home, school
CAMHS fourth aspect to consider for recovery
Joined up way of working – not taking child in isolation
Growing problem
Pandemic made it worse
Withdrawal as way of coping with discomfort pain and suffering
Helpful to reflect on it
Degree of the problem

3. Clustering of Experiential Statements from Interview 2

Clusters of Experiential Statements

Cluster A: What is it? Description of social withdrawal
School Refusal
Social withdrawal from peers
Struggles with getting out of bed
Getting worse, escalating from withdrawal from school to withdrawal from friends

Cluster B: Who does it affect?
Adolescent girl
Adolescent boy
Younger child
12-year-old boy known to CAMHS since 7-8 years old

Cluster C: What contributes to it?
Parental mental health difficulties – intergenerational picture of trauma
Parental mental health difficulties
Parental mental health difficulties shake secure base
Family difficulties greater than pandemic
Impact of mother's conflictual relationships
Caught up in a system of family dynamics
Intergenerational picture of trauma
Impact on child
Childhood trauma: loss of father
Shared unspoken mental state
Losses and changes
Parental mental health difficulties
Losses
Trauma
Pain
Sadness
Loneliness
Conflict
Loneliness in parent
Loneliness underneath capable thoughtful resourceful professional parent
Unpredictable unsecure base

Base unstable and unpredictable
Trauma in social withdrawal – wall to break through

Family relational problems – Boundaries and separation issues
Enmeshment between mother and child
Difficulty in separating when parent not safe
Ordinary flow between independence and dependence during adolescence not possible
Parental ambivalence at separation
Worry and mistrust at letting go of the other
Parent's projections in child to remain a child?
Fear of parental feelings in relation to growing up, separating, succeeding?
No freedom to let go and leave someone behind safely as developmentally appropriate
Adopting parental responsibility
Overprotection of parents
The role of the mother
YP different without parent
Expressing what parent cannot hear
Whose need is it to remain in a younger position?
Increase in openness, capability, age-appropriateness without parent
Freedom to be competent, more independent self without parent

The pandemic
Pandemic impact
Change during and after pandemic
Pandemic triggered previous traumatic loss
Pandemic: forced loss of current life rewoke early traumatic loss
Pandemic: Loss of identity while forming
Pandemic: loss of usual life and support system for parent
Pandemic made it worse

Intertwin between the external and internal processes
Added developmental and external pressures test the base
Insecure base cannot withstand added pressures
When the external situation mirrors an internal one
Internal - external imprisonment
Impossibility of recovering with only external change as internal state set in motion

Cluster D: What are the young people doing in relation to withdrawal?
Ambivalence
Contrast between wish to get better and rejecting help
Girl ambitious and keen to do well
Contrast between wish to come out of withdrawal and behaviour getting worse
Cutting off, withdrawing, but utter dependence

Dependence and cutting off
Cutting off from parent
Conflict between self-views and views from parent
Separation processes in adolescence
Conflicted wishes for more separation and less enmeshment
Disruption of process of separation if additional pressures
Ordinary separation not possible
Struggle to find more solid actual independence
Conflicted wishes for separation expressed in cutting off to avoid experiencing pain and loss of real separation
Stuck between wish for independence and utter dependence

Omnipotence – illusion of no needs
Reversal of Oedipal dynamic
Avoidance of any separation and awareness of need by cutting off

Collapsed space for growth
Enmeshment
Claustrophobic internal place – no space for self
No space between parental and child's feelings
Locking self into small place
Retreat from conflict between infantile self and older self
Retreat to the womb
Anti-life wish

Early defences against disintegration
Paranoid-schizoid position
Splitting
Social withdrawal: defensive function in the face of an unsecure base
Withdrawal as way of coping with discomfort, pain and suffering

Cluster E: What is the impact?
Profound isolation
Impact on freedom to leave home and live their lives
External-internal isolation difficult to sustain over time – it leads to more isolation
Relief only initial
Profound sadness
Countertransference - abandoned little boy
Depression and anxiety setting in
Pain and immense need

Concerns in clinicians
Therapist concerned around risks

Cluster F: Barriers to recovery
Systemic issues
System at a loss
Entrenched issue before help is sought
Growing problem
High workload

Boundaries
Difficulty in separating in treatment too
Challenges to boundaries
Difficulty in addressing unhelpful dynamics in parents
Risk of being pulled into relationship dynamics at play

An entrenched issue
Lack of touch with loss linked with deterioration
Degree of the problem
Complex issue
Alarm at problem set in for 3 months

Cluster G: Interventions
Long-term support
Multiple interventions
Individual specific mental health interventions at later stage

Specific individual intervention after initial priority attended to
Later intervention to address trauma due to parental mental health
Intervention: holding sessions for parent and child first
When more stable, individual intervention offered
Could make use of therapeutic intervention only after acute phase attended to
Step by step approach for YP and parent

Focusing on a priority and remaining boundaried
Primary effective intervention: Finding a priority
Primary effective intervention: Remaining focused on priority
Role of clinician maintaining some distance to focus on main task
Need for boundaries in the approach
Need not to act out the projection of unmet need from family and system
Not feeling useless and paralysed but remaining hopeful and focused on gradual steps
Separation and space allow processing own feelings
Own space to express self without worry about parent's feelings

Joined work
Joined up work
Primary effective intervention: Network support
Containing function of network meetings for family
Need for parent to be contained
Need to contain splitting by bringing people together
Medication useful in acute crisis
Acute phase helped by medication
Clinical approach around three aspects at the same time: Child, home, school
CAMHS fourth aspect
Joined up way of working – not taking child in isolation
Helpful to reflect on it
Negotiating conditions that allow gradual re-integration
What helped maintain focus: Working with others, not in isolation

Cluster H: Road to Recovery: through awareness of loss and retrieval of hope
Wish to recover and being in touch with loss helps treatment
Coming together to think and listen to each other
Parent feeling heard
What helped maintain focus: Getting in touch with loss and sadness
What helped maintain focus: Getting in touch with potential and hope
Contingencies, steps and options helped young person

Table 4. Creation of Personal Experiential Themes from Interview 2

Personal Experiential Themes
Theme 1. An escalation from school refusal
School Refusal
Social withdrawal from peers
Struggles with getting out of bed
Getting worse, escalating from withdrawal from school to withdrawal from friends
Theme 2. Adolescents and younger children transitioning to secondary school
Adolescent girl
Adolescent boy
Younger child

12-year-old boy known to CAMHS since 7-8 years old

Theme 3. Boys are mainly affected
Adolescent girl
Adolescent boy
Younger child
12-year-old boy known to CAMHS since 7-8 years old

Theme 4. Parental mental health difficulties and intergenerational trauma
Parental mental health difficulties
Parental mental health difficulties shake secure base
Family difficulties greater than pandemic
Impact of mother's conflictual relationships
Caught up in a system of family dynamics
Intergenerational picture of trauma
Impact on child
Childhood trauma: loss of father
Shared unspoken mental state
Losses and changes
Parental mental health difficulties
Losses
Trauma
Pain
Sadness
Loneliness
Conflict
Loneliness in parent
Loneliness underneath capable thoughtful resourceful professional parent
Unpredictable unsecure base
Base unstable and unpredictable
Trauma in social withdrawal – wall to break through

Theme 5. Boundaries and separation issues in family relationships
Enmeshment between mother and child
Difficulty in separating when parent not safe
Ordinary flow between independence and dependence during adolescence not possible
Parental ambivalence at separation
Worry and mistrust at letting go of the other
Parent's projections in child to remain a child?
Fear of parental feelings in relation to growing up, separating, succeeding?
No freedom to let go and leave someone behind safely as developmentally appropriate
Adopting parental responsibility
Overprotection of parents
The role of the mother
YP different without parent
Expressing what parent cannot hear
Whose need is it to remain in a younger position?
Increase in openness, capability, age-appropriateness without parent
Freedom to be competent, more independent self without parent

Theme 6. The role of the pandemic
Pandemic impact
Change during and after pandemic
Pandemic triggered previous traumatic loss
Pandemic: forced loss of current life rewoke early traumatic loss

Pandemic: Loss of identity while forming
Pandemic: loss of usual life and support system for parent
Pandemic made it worse
When the external situation mirrors an internal one
Internal - external imprisonment
Impossibility of recovering with only external change as internal state set in motion

Theme 7. The trigger of added external pressures
Added developmental and external pressures test the base
Insecure base cannot withstand added pressures

Theme 8. Ambivalence about recovery
Contrast between wish to get better and rejecting help
Girl ambitious and keen to do well
Contrast between wish to come out of withdrawal and behaviour getting worse

Theme 9. Between cutting off and dependence
Cutting off from parent
Separation processes in adolescence
Conflicted wishes for more separation and less enmeshment
Disruption of process of separation if additional pressures
Ordinary separation not possible
Struggle to find more solid actual independence
Conflicted wishes for separation expressed in cutting off to avoid experiencing pain and loss of real separation
Stuck between wish for independence and utter dependence
Omnipotence – illusion of no needs
Reversal of Oedipal dynamic
Avoidance of any separation and awareness of need by cutting off
Cutting off, withdrawing, but utter dependence

Theme 10. Collapsed space for growth
Enmeshment
Claustrophobic internal place – no space for self
Conflict between self-views and views from parent
No space between parental and child's feelings
Locking self into small place
Retreat from conflict between infantile self and older self
Retreat to the womb
Anti-life wish

Theme 11. Early defences against disintegration
Paranoid-schizoid position
Splitting
Social withdrawal: defensive function in the face of an unsecure base
Withdrawal as way of coping with discomfort, pain and suffering

Theme 12. Profound sadness
Impact on freedom to leave home and live their lives
External-internal isolation difficult to sustain over time – it leads to more isolation
Relief only initial
Profound sadness
Countertransference - abandoned little boy
Depression and anxiety setting in
Pain and immense need

Theme 13. Serious concerns around young persons' wellbeing
Therapist concerned around risks
Alarm at problem set in for 3 months
Lack of touch with loss linked with deterioration
Degree of the problem
Complex issue

Theme 14. Systemic barriers to recovery
System at a loss
Entrenched issue before help is sought
Growing problem
High workload

Theme 15. Challenges to boundaries
Difficulty in separating in treatment too
Challenges to boundaries
Difficulty in addressing unhelpful dynamics in parents
Risk of being pulled into relationship dynamics at play

Theme 16. The need for long-term interventions
Multiple interventions
Individual specific mental health interventions at later stage
Specific individual intervention after initial priority attended to
Later intervention to address trauma due to parental mental health
Intervention: holding sessions for parent and child first
When more stable, individual intervention offered
Could make use of therapeutic intervention only after acute phase attended to
Step by step approach for YP and parent

Theme 17. Focusing on a priority and remaining boundaried
Primary effective intervention: Finding a priority
Primary effective intervention: Remaining focused on priority
Role of clinician maintaining some distance to focus on main task
Need for boundaries in the approach
Need not to act out the projection of unmet need from family and system
Not feeling useless and paralysed but remaining hopeful and focused on gradual steps
Separation and space allow processing own feelings
Own space to express self without worry about parent's feelings

Theme 18. Working together
Joined up work
Primary effective intervention: Network support
Containing function of network meetings for family
Need for parent to be contained
Need to contain splitting by bringing people together
Medication useful in acute crisis
Acute phase helped by medication
Clinical approach around three aspects at the same time: Child, home, school
CAMHS fourth aspect
Joined up way of working – not taking child in isolation
Helpful to reflect on it
Negotiating conditions that allow gradual re-integration
What helped maintain focus: Working with others, not in isolation

Theme 19. Gradual recovery

Wish to recover and being in touch with loss helps treatment
Coming together to think and listen to each other
Parent feeling heard
What helped maintain focus: Getting in touch with loss and sadness
What helped maintain focus: Getting in touch with potential and hope
Contingencies, steps and options helped young person

Appendix F: Thematic Tables

This section shows how the researcher proceeded to form group themes: Group Experiential Themes. The process, reported below, involved listing all Personal Experiential Themes from all interviews and identifying recurrent themes across the interviews. The resulting main Group Experiential Themes with their subthemes are also reported below.

Table 1. List of Personal Experiential Themes from each participant

Participant 1	***Participant 2***
Theme 1. An escalation from school refusal	Theme 1. An escalation from school refusal
Theme 2. Adolescents and younger children transitioning to secondary school	Theme 2. Adolescents and younger children transitioning to secondary school
Theme 3. Boys are mainly affected	Theme 3. Boys are mainly affected
Theme 4. Parental mental health difficulties and intergenerational trauma	Theme 4. Parental mental health difficulties and intergenerational trauma
Theme 5. The role of the pandemic	Theme 5. Boundaries and separation issues in family relationships
Theme 6. The trigger of added external pressures	Theme 6. The role of the pandemic
Theme 7. Issues of identity: seeing oneself and being seen	Theme 7. The trigger of added external pressures
Theme 8. Anonymity and invisibility	Theme 8. Ambivalence about recovery
Theme 9. Collapsed space for growth	Theme 9. Between cutting off and dependence
Theme 10. Between cutting off and dependence	Theme 10. Collapsed space for growth
Theme 11. Withdrawing from life	Theme 11. Early defences against disintegration
Theme 12. Some links with life	Theme 12. Profound sadness
Theme 13. Anger and frustration	Theme 13. Serious concerns around young persons' wellbeing
Theme 14. Serious concerns around young persons' wellbeing	Theme 14. Systemic barriers to recovery
Theme 15. Hopelessness for a way forward	Theme 15. Challenges to boundaries
Theme 16. Systemic barriers to recovery	Theme 16. The need for long-term interventions
Theme 17. The experience of inaccessible young people	Theme 17. Focusing on a priority and remaining boundaried
Theme 18. The need for long-term interventions	Theme 18. Working together
Theme 19. Gradual contact in therapeutic encounter	Theme 19. Gradual recovery
Theme 20. The power of a flexible approach	

Theme 21. Fostering contact with reality through boundaries	
Theme 22. Working together	
Theme 23. Gradual recovery	

Participant 3	***Participant 4***
Theme 1. An escalation from school refusal	Theme 1. An escalation from school refusal
Theme 2. Adolescents and younger children transitioning to secondary school	Theme 2. Adolescents and younger children transitioning to secondary school
Theme 3. Girls are mainly affected	Theme 3. Boys are mainly affected
Theme 4. Parental mental health difficulties and intergenerational trauma	Theme 4. Parental mental health difficulties and intergenerational trauma
Theme 5. Boundaries and separation issues in family relationships	Theme 5. Boundaries and separation issues in family relationships
Theme 6. The role of the pandemic	Theme 6. Prolonged period at home tantalising
Theme 7. The trigger of added external pressures	Theme 7. Ambivalence about recovery
Theme 8. Ambivalence about recovery	Theme 8. Withdrawing from life
Theme 9. Withdrawing from life	Theme 9. Collapsed space for growth
Theme 10. Despair	Theme 10. Between cutting off and dependence
Theme 11. Anger and frustration	Theme 11. Serious concerns around young persons' wellbeing
Theme 12. Precariousness	Theme 12. Anger and frustration
Theme 13. Systemic barriers to recovery	Theme 13. Hopelessness for a way forward
Theme 14. The experience of inaccessible young people	Theme 14. Systemic barriers to recovery
Theme 15. Complexity of an entrenched problem	Theme 15. The experience of inaccessible young people
Theme 16. The need for long-term interventions	Theme 16. Complexity of an entrenched problem
Theme 17. Working on separation issues	Theme 17. The need for long-term interventions
Theme 18. The power of a flexible approach	Theme 18. Fostering contact with reality through boundaries
Theme 19. Working together	Theme 19. Working together
Theme 20. The need for a more supportive school system	Theme 20. Gradual recovery
Theme 21. Gradual recovery	

Table 2. Identifying recurrent themes

Theme	1	2	3	4	>/= half
An escalation from school refusal	Y	Y	Y	Y	**Y**
Adolescents and younger children transitioning to secondary school	Y	Y	Y	Y	**Y**
Boys are mainly affected	Y	Y		Y	**Y**
Parental mental health difficulties and intergenerational trauma	Y	Y	Y	Y	**Y**
The role of the pandemic	Y	Y	Y		**Y**
The trigger of added external pressures	Y	Y	Y		**Y**
Issues of identity: seeing oneself and being seen	Y				
Anonymity and invisibility	Y				
Collapsed space for growth	Y	Y		Y	**Y**
Between cutting off and dependence	Y	Y		Y	**Y**
Withdrawing from life	Y		Y	Y	**Y**
Some links with life	Y				
Anger and frustration	Y		Y	Y	**Y**
Serious concerns around young persons' wellbeing	Y	Y		Y	**Y**
Hopelessness for a way forward	Y			Y	**Y**
Systemic barriers to recovery	Y	Y	Y	Y	**Y**
The experience of inaccessible young people	Y		Y	Y	**Y**
The need for long-term interventions	Y	Y	Y	Y	**Y**
Gradual contact in therapeutic encounter	Y				
The power of a flexible approach	Y		Y		**Y**
Fostering contact with reality through boundaries	Y			Y	**Y**
Working together	Y	Y	Y	Y	**Y**
Gradual recovery	Y	Y	Y	Y	**Y**
Boundaries and separation issues in family relationships		Y	Y	Y	**Y**
Ambivalence about recovery		Y	Y	Y	**Y**
Early defences against disintegration		Y			
Profound sadness		Y			
Challenges to boundaries		Y			
Focusing on a priority and remaining boundaried		Y			
Girls are mainly affected			Y		
Despair			Y		
Precariousness			Y		
Complexity of an entrenched problem			Y	Y	**Y**
Working on separation issues			Y		
The need for a more supportive school system			Y		
Prolonged period at home tantalising				Y	

Table 3. Themes present in >/= half the sample

Theme	Out of total

An escalation from school refusal	4/4
Adolescents and younger children transitioning to secondary school	4/4
Parental mental health difficulties and intergenerational trauma	4/4
Systemic barriers to recovery	4/4
The need for long-term interventions	4/4
Working together	4/4
Gradual recovery	4/4
Boys are mainly affected	3/4
The role of the pandemic	3/4
The trigger of added external pressures	3/4
Collapsed space for growth	3/4
Between cutting off and dependence	3/4
Withdrawing from life	3/4
Anger and frustration	3/4
Serious concerns around young persons' wellbeing	3/4
The experience of inaccessible young people	3/4
Boundaries and separation issues in family relationships	3/4
Ambivalence about recovery	3/4
Hopelessness for a way forward	2/4
The power of a flexible approach	2/4
Fostering contact with reality through boundaries	2/4
Complexity of an entrenched problem	2/4

Table 4. Main Group Experiential Themes and subthemes - with recurrent Individual Personal Themes underneath

Group Experiential Themes and Subthemes:
Theme 1. The what and the who
1a. School Refusal
An escalation from school refusal
1b. Male adolescents and younger children
Adolescents and younger children transitioning to secondary school *Boys are mainly affected* *Girls are mainly affected*
Theme 2. Contributing Factors
2a. Parental difficulties
Parental mental health difficulties and intergenerational trauma *Boundaries and separation issues in family relationships*
2b. Added external pressures
The trigger of added external pressures

2c. The pandemic
The role of the pandemic
Theme 3. A retreat from life
3a. Between a wish to connect and cutting off: a denial of dependence
Ambivalence about recovery
Between cutting off and dependence
3b. Collapsed space for growth
Collapsed space for growth
3c. Withdrawing from life
Withdrawing from life
Anonymity and invisibility
Theme 4. An entrenched problem
4a. The emotional impact
Anger and frustration
Serious concerns around young persons' wellbeing
Hopelessness for a way forward
4b. Barriers to recovery
Systemic barriers to recovery
The experience of inaccessible young people
Complexity of an entrenched problem
Theme 5. The road to recovery
5a. Interventions
The need for long-term interventions
The power of a flexible approach
Fostering contact with reality through boundaries
Working together
5b. A gradual recovery
Gradual recovery