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Hikikomori: contemporary forms of suffering in the transition from adolescence to adulthood

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Abstract

Introduction: Since the emergence of Hikikomori syndrome in Japanese literature, special attention has been given to this phenomenon all over the world concerning adolescents and young adults. Several questions have risen: the novelty or not of such syndrome, its psychopathological and nosographical status, but also its social and cultural implications.

Material and method: We have first realized an analysis of studies published in French in order to confront them with the reference studies of international literature. As soon as 1950, a description of a "claustration syndrome" occurred with its psychological implications and transnosographical, mainly based on adult subjects. During the 2000's, the interest for these adolescent behaviours increase, stressing the complexity both of its functioning and the treatment modalities, but also the access to these young secluded. Then we present two forms of Hikikomori, built after a clinical study of a cohorte of 30 adolescents, and illustrated them by to two clinical vignettes

Results and discussion: The predominance of Hikikomori among boy teenagers and young adults has led us to explore the functions of this behaviour during adolescence and its specific stakes: excitement treatment, passivity treatment, confrontation with loss and with ideal's demand. We make the hypothesis of a double figure of Hikikomori. The first concerns temporary and defensive adjustments of conflicts, the other stresses the impossibility to treat the adolescence process. Therefore, the therapeutically propositions have to take into account these two figures of Hikikomori.

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1. Introduction

The hikikomori phenomenon emerged in the late twentieth century as a new form of withdrawal behaviour in adolescents and young adults. It is an interesting phenomenon, showing as it does a contemporary variant in how young men, in particular, express their suffering. Previously, male adolescents had tended to resort to active behaviour patterns such as thrill seeking and drug abuse to relieve internal tensions. These patients, who are now termed hikikomori (pulling inward or being confined in Japanese), remain cloistered in their room, thus shunning relationships and school or professional commitments. They seem to be on hold, between adulthood that has not yet arrived and childhood that has become a thing of the past. Much of their mental energy is devoted to avoiding any change or any move towards change.

Over the last century, withdrawal behaviours were described in French-language literature as a "*claustration syndrome*" (Gayral, 1953). Gayral differentiated between pathological and non-pathological forms, and active or passive withdrawal. In the active mode, the patient's relationships with society are often (but not necessarily) informed by aggression and hostility. Passive withdrawal is materially more or less organised and the patient's relation to the surrounding world generates indifference, contempt, arrogance, anger or disgust. These different forms of withdrawal (*claustration*) point to the essential role of relationships with others and society, which are not restricted to the effects of withdrawal that delusional activities or invasive negativism generate. Meanwhile, in the English-language literature, withdrawal behaviour is frequently referred to as the housebound syndrome, primarily affecting women (Kraft, 1970; Rap, 1984).

Until recently, apart from works on psychotic disorders or agoraphobia in adults, little scientific attention has been paid to such forms of withdrawal behaviour. Since the year 2000, the clinical approach to adolescence has led to a revival of interest in the phenomenon, especially with the emergence of hikikomori in Japan (Saito, 1998). The hikikomori concept has since seen worldwide success, becoming for some experts a modern pandemic (Yuen et al., 2018), a global health problem (Wu et al., 2019) or a form of "*hikikomania*" (Todd, 2011). Many studies into hikikomori have been conducted on large cohorts in Asian countries including Hong-Kong (Wong et al., 2015) and Korea (Lee et al., 2013). These studies sought to determine the presence of hikikomori among populations of adolescents and young adults and showed that severe withdrawal behaviours existed in those countries as in Japan. They highlighted the high frequency of anxiety and addictive-depressive comorbidity (Malagon-Armor et al., 2014; Stip et al., 2006).

In others countries, the focus has been more on single cases or more or less significant groups of hikikomori, as in Canada (Stip et al., 2006), France (Chauillac et al., 2017) and Spain (Malagon-Amor et al., 2014) where studies highlighted the frequency of severe withdrawal patterns among adults suffering from psychotic disorders.

In Italy (Ranieri, 2015) and in Ukraine (Frankova, 2007) the authors pointed to the relevance of dysfunctions in early mother-child relationships among adolescents and young hikikomori adults. Insecure attachment and the child's need to reassure his or her mother limit the child's access to autonomy and contribute to relational difficulties during adolescence. Some authors stress the need for specialised teams in managing these patients (Ranieri & Luccherino, 2018; Sakamoto et al., 2005).

For Teo (Teo & Gaw, 2010), the hikikomori syndrome is intertwined with cultural issues and the challenges encountered when entering adulthood, the imperatives of success and social and familial expectations, which are especially strong in Japan. However, such pressures also exist in others countries and the Diagnostic and Statistical Manual of Mental Disorders (DMSV) Task Force rejects this national-cultural perspective since the hikikomori syndrome has also emerged in many other countries. They propose the term be assigned to the category of "idioms" (cultural expression of a disorder). In our view, hikikomori can be interpreted as a modern form of expression of the suffering of adolescents as they respond to high family and social expectations accompanied by intense mental excitation and the exigencies of personal ideals (De Luca, 2017).

Whether seen as a behaviour or a syndrome, cases of hikikomori are encountered in extremely varied and often complex situations due to the combination of psychopathological, family and sociocultural issues. A clinical approach to this form of withdrawal should also take into account these other social and cultural aspects to achieve a better understanding. A non-clinical approach to hikikomori is adopted in Japan with a strong social strand even informing treatment (Stip, 2019). In Japanese mythology, the goddess Amaterasu is one of the first figures of voluntary retreat, leaving her royal destiny after a conflict with her brother (De Luca, 2019). The other deity figure is the goddess Izanami, shut away with the dead in the land of Yomi (a legend that for westerners recalls that of Orpheus and Eurydice) (Kitayama, 2010). The sociological approach focused on amae and shame. Amae as described by Doi (1973) is a particular type of mother and child relationship, to be loved with a total indulgence and a major dependence. In this over-dependent link, the child behaves according to the belief that the parent will forgive everything and allow them to stay at home. Japanese culture is also often associated with a tradition of shame, as illustrated in its most extreme version of resorting to *hara-kiri*.

Being shamed is seen to be a prelude to acting virtuously and removing oneself from society. This kind of mind-set may help explain why social withdrawal is such an obvious solution for vulnerable Japanese adolescents or young adults. However, isolation also provides adolescents with a means to protect themselves in clinical situations other than hikikomori per se, as in cases of obesity (Merlo et al., 2018).

Over the last ten years or so, we have observed in our clinical practice the emergence of severe forms of withdrawal in adolescents and young adults without those patients necessarily showing any signs of severe psychopathology. Based on this clinical experience, we wish to examine not only the position of the syndrome in the fields of psychiatry and psychopathology but also aspects relating to its social and cultural expressions. Here, we propose a psychodynamic approach to better understand the underlying challenges of the symptomatic expressions, relying on a specific clinical research method. Exploring this psychopathologic dimension can still be problematic for the clinician (Frankova, 2019).

Our research took place in a French psychiatric department for adolescents and young adults and was based on a cohort of 30 hikikomori. All were hospitalised in a psychiatric department due to severe withdrawal and dropping out of school. Two subgroups were identified. In the first and larger group, withdrawal accompanied a suspension of the process of adolescence. In the second, the symptomatology was more severe and the dynamics of entering adulthood were clearly hindered. The choice was made to present two clinical vignettes from each group as being paradigmatic of the similarities prevailing in each of the two groups. These similarities unfolded along four dimensions that were particularly mobilised in these patients: the function of inhibition as a modality of processing excitement, claustration as a refusal of the passiveness that is inherent in adolescence, withdrawal as an expression of a struggle with depression, and confrontation with measureless ideals.

2. Material and Methods

2.1 Hikikomori: a methodological paradox and clinical challenge

While clinicians and researchers often express conflicting views, they still have to face the same methodological paradox with hikikomori, i.e. the issue of meeting subjects who seek to remain confined to their homes. An alliance may therefore emerge between the two camps as they seek to understand the phenomenon.

Few publications focus essentially on meetings with these withdrawn adolescents. Such encounters take place in the home, in a medical centre, in a psychiatric hospital or even via skype (Hattori, 2006) or phone (Lee et al., 2013). Resorting to case reports is a frequently adopted

approach. Meanwhile, meeting hikikomori in their personal environment remains a real challenge for clinicians as they seek to get to grips with this uncommon experience, studying the setting so as to be able to adopt a phenomenological methodology. Such direct observation allows for a greater understanding of the feelings these withdrawn adolescents experience and the way they live in their room. Drawing on such direct experience, Saito (Saito, 2013) was able to highlight one of the issues at stake in severe withdrawal behaviours for those who have not yet reached adulthood. One of his major postulates concerned the difficulties of making the transition to adulthood for hikikomori who prevaricate by adhering to a never-ending adolescence as is evidenced in the very title of his work *Adolescence without end* (2013). Adopting a clinical methodology as in case reports is also of interest due to the extreme diversity of psychic functioning, as in Ranieri & Luccherino (2018) who evoke the proteiform expressions of hikikomori. The clinical method based on singular case studies allows for a more in-depth exploration of psychic functioning and helps formulate more general hypotheses that can then be put to the test through studies on larger population groups (De Luca, 2020). However, few studies adopt a psychodynamic approach focusing on deep psychological functioning (Wilson, 2010) although the Rorschach test is sometimes used. However, demonstrable difficulties in emotional expression, in becoming independent, and a heightened passive aggressiveness are noted (Katsuki, 2019).

An alternative approach to studying withdrawn adolescents is indirect through reading their letters or other writings and blogs (Yong & Kaneto, 2016) or even their chat on twitter (Pereira-Sanchez et al., 2019) with the aim of listening to them and analysing their narrative experience (Caputo, 2020). Interviewing their families provides another indirect avenue to seek an understanding of hikikomori. These families generally appear to be "normal", and none of them conveys any suffering at the idea of having their child cloistered at home for months or even years. The situation seems almost to reassure them, precluding the need to handle the issue of separation, sometimes confused with death or permanent loss (De Luca & Neau, 2016). However, despite this apparent normality, some marked family characteristics are described in the literature (Umeda & Kawakami, 2012), as with fragmented families (Chong & Chan, 2012), poor social support (Borovoy, 2008), single parent families (Malagon-Amor, 2019), the death of a parent (Kondo et al., 2011) and a history of psychiatric problems (Malagon-Amor et al., 2015). The expression of conflict is often repressed, and fear of others and lack of empathy is a driving force in these children (Heinz & Thomas, 2014; Todd, 2011). However, in certain cases family conflicts are mentioned, always revolving around the fathers, even when the latter are away or absent (Suryhina, 2017).

In Japanese studies into hikikomori family relationships, a trend towards maternal overprotection is also highlighted (Li, 2015; Teo, 2009). Studies have also focused on emotional expression and forms of communication in hikikomori families but have not indicated a behavioural repertoire different to that in non-hikikomori families (Nonaka et al., 2019).

The hikikomori phenomenon has been and continues to be a real challenge for clinicians, particularly with regard to the question of the normal and the pathological. In the Japanese government's definition criteria, the absence of mental illness is essential. This position raises many questions about the status of hikikomori and possible associated comorbidities. N. Tajan (2015), observes three main currents of understanding in the literature about hikikomori. Firstly, some authors propose a binary opposition whereby either all hikikomori can be seen to have a psychiatric pathology or none of them have any mental disorder, since such behaviour is a response to sociological changes in Japan. Secondly, the hikikomori condition is considered as a contemporary form of mental illness similar to schizophrenia, severe depression, avoidant personality or social anxiety (Teo et al., 2015). Finally, for some authors, there are two types of hikikomori (Kato et al., 2020), the first being free of any mental illness while the second is an integral part of a mental disorder. For Suwa (Suwa & Suzuki, 2003) hikikomori is not indicative of mental disorder (is "not a manifest mental disorder") but this raises doubts as to this binary opposition, due to the qualification applied with "not a manifest". Indeed, the absence of psychiatric diagnoses may relate to the lack of detailed evaluations and absence of prolonged monitoring. Hikikomori might share some characteristics with the prodromal signs of schizophrenia (Kondo et al., 2013. Stip et al., 2016) or with schizoid personalities, especially when young adults are evaluated based on adult criteria. A comparative study of more than 300 cases of hikikomori shows that the most frequent diagnoses with DSM criteria is personality disorder (avoidant personality in most instances), major depression disorder (Koyama et al., 2010; Nagata et al., 2011) or even a modern type of depression (Kato, 2016), and social anxiety disorder. Meanwhile, for 60% of subjects, hikikomori corresponded to criteria for multiple psychiatric diagnoses (Teo et al., 2015) and real risk of suicidal behaviour (Yong & Nomura, 2019). Comorbidity exists with autism spectrum disorder (Kondo et al., 2013) and neurodevelopment disorder (Furuhashi & Vellut, 2015). Hikikomori are more likely to drop out of education and have a history of psychiatric treatment as compared with non-hikikomori adults (Yong & Nomura, 2019). This pathological/non-pathological opposition also emerges when seeking to determine the link between hikikomori and online gaming or Internet browsing. Internet addicts and hikikomori share common characteristics, such as dropping out of school, abandoning any professional project, reducing or avoiding social relationships and, of course, intensive use of the Internet and online games. The IT revolution is associated with

the development of social withdrawal, not only from the perspective of addiction, but also in relation to greater feelings of loneliness, higher levels of anxiety and depression (Twenge, 2017) and patterns of bullying (Fujikawa et al., 2018). Cases of pathological gambling in adolescence without necessarily being accompanied by severe withdrawal have also been observed (Sideli et al., 2018). In such cases, hikikomori is seen to be a reactional behaviour rather than a syndrome. Addiction to cannabis among hikikomori adolescents is also described in the literature (Stip, 2014).

2.2 A psychodynamic approach

A psychodynamic approach adopting a processual clinical research method to analyse the underlying challenges of symptomatic expressions of hikikomori would appear to offer a promising perspective. This psychopathological perspective allows for a transnosographic analysis of hikikomori, overcoming the divide between those who posit a syndrome devoid of any psychiatric illness and those who integrate the condition into a broader category of depressive or anxiety related conditions, sometimes even seen as being on the threshold of psychosis. The clinical diversity encountered in hikikomori can thus be taken into account, whether in early adolescence/adulthood, over the course of a few months/several years, or even in behaviour patterns of complete isolation/aggressiveness.

Some Japanese specialists now propose a bio-psycho-socio-cultural model including psychiatric conditions of anhedonia, anxiety and delusion and non-psychiatric states such as shame, loneliness, the Internet/IT society or interdependent society (Yong & Nomura, 2019). The psychodynamic approach pursues this same willingness to open up to reflection not centred on categories but rather on the processes involved in the contemporary expression of suffering in adolescence. This opens the way to taking into consideration the specifics of adolescence as the subject constructs his or her identity, undergoing multiples changes in the process. Adult-based nosography is too rigid structure to describe these adolescent's process and their related transformations. To effectively understand this behaviour, it is important to consider it within the context of a continuum between the normal and the pathological and not under a normal/pathological dichotomy that would tend to exaggerate the pathological side. This approach also overcomes the potential threshold effects induced by the definition of at least 6 months of withdrawal at home. Such a duration already seems over-long within the shifting context of adolescence where there is always the risk of quickly settling into a behaviour pattern with serious individual, social and family consequences. Thus, in recent work the notion of a pre-hikikomori condition after 3 months of withdrawal is described (Tan et al., 2020). Arguing a continuum between the normal and the pathological and deploying a psychodynamic approach

on Freudian lines appears to us to privilege a processual interpretation of the symptoms, thus overcoming the stasis of an approach based on nosography.

Clinical work with adolescents underlines the importance of taking into account the processual dimension of psychic functioning. Symptomatic expression at this age is complex, involving the superficial and what is deeply felt, what is manifest and what is latent. Severe withdrawal is a part of this complexity where individual, historical, developmental, intrapsychic and family specifics can combine with invariants characteristic of the group of adolescent and young adult hikikomori. The psychodynamic approach appears best suited to address this complexity. Following the example of other authors, we sought to avoid the sterile opposition between clinical and research methods (Coppola & Mento, 2013). Discrepancies between the data observed in single cases and in the cohort as a whole allow invariants found in all subjects to be identified. These invariants thus contribute to a better understanding of what is common to all hikikomori and will be the subject of further studies to be consolidated.

Our clinical encounters with several adolescents and young adults allowed us to formulate hypotheses structured around four dimensions: inhibition, refusal of passiveness, struggle with depression and confrontation with measureless ideals. We formed a cohort of 30 patients: 5 girls and 25 boys from 12 to 20 years old. The average age was 14.5 years for boys and 16 years for girls. The average withdrawal period was 20 months. The main diagnosis was based on mood disorder, followed by anxiety and phobic disorders and then psychotic disorders. On the lines of our hypothesis as to the specifics of their psychic functioning, we formed two groups with similarities. These two groups were illustrated through two clinical vignettes.

The first group, represented by Albert, 15 years old, falls under the realm of transitory adjustments that serve the passage from adolescence to adulthood. The second group, illustrated by Augustin, 20 years old, is already caught up within the rigidification of mental functioning likely to lead to pathological fixations.

3. Results

We chose to illustrate two forms of hikikomori as represented respectively by Albert and Augustin (pseudonyms). They belonged to a cohort of 30 subjects encountered in a psychiatric department for adolescents and young adults in the Paris suburbs. All 30 subjects signed a consent form for research and publication. All these hikikomori teenagers were hospitalised due to severe withdrawal. Most were hospitalised on request from their parents, some of whom had come in for consultation on several occasions in preparation for their children's hospitalisation. Others had been hospitalised on request from their attendant physician or from their school due to them having dropped out. Finally, for six of them, a mobile psychiatric team had

intervened at their homes to take them into emergency care due to the imminent threat of self-harm or hetero-aggression. A large majority of these teenagers were against being hospitalised. Meanwhile, the others were seeking help not only for care but also for educational support. The care offered was either provided in an intensive care inpatient unit for adolescents or in a care and school reintegration unit where they benefited from small class sizes with dedicated teaching staff.

Albert is a 15-year-old teenager who had not left his room for more than a year. He had retreated there 6 months after his mother's death caused by her alcoholism, a pattern frequently described among hikikomori families (Stip et al., 2016). Having refused to attend school, he sought help from a child psychiatrist. Then, having failed to turn up for consultation and take part in therapeutic activities, he was hospitalised. The constraint of hospitalisation (with the paradox of being locked into a hospital room when he was no longer leaving his room so as not to lose the memory of his mother) as well as resuming relations with other adolescents allowed Albert to engage in face-to-face psychotherapy interviews. In this situation, he was able in quite a short time to resume his schooling and invest in friendly and social relations. Investment in the therapeutic relationship was from the outset massively taken up in a positive transference with a high level of commitment in psychotherapy and therapeutic activities. There was no expression of opposition or aggressiveness during the first weeks of hospitalisation. During hospitalisation, therapeutic investment gradually evolved towards a more negative dimension of anger, a deployment of the anger never expressed towards the mother who effectively abandoned him. His request for rapid discharge from hospital bore witness to this, as if, faced with the risk of a painful separation, it was better to choose to break the bond, be active rather than passive towards the other.

Augustin is a 20-year-old adult. He had not left his room for five years. His parents chose to come in for consultation to discuss their son's future, fearing what would become of him after their deaths. Augustin had made a suicide attempt at the age of 13 in a context of harassment at school. Following this he was briefly hospitalised where schizophrenia was diagnosed and antipsychotic treatment dispensed. However, he quickly ended the treatment due to putting on weight. He did not return to school and lived at his parents' home until the day he turned 15 when he went to Switzerland with his savings "to seek his fortune". Everyone then lost track of him until he was found one month later, penniless, wandering around an African city. He was then repatriated. Augustin was hospitalised following a crisis of unrest at home. He was cold and distant towards others when he arrived and personal interactions terrified him. However, he gradually emerged from his hospital room and began to engage in therapeutic activities. Consultation with his parents prepared for him to leave the hospital with ambulatory follow-up

care being proposed. However, the therapeutic relationship remained extremely superficial. The different therapists seemed to be interchangeable and it was difficult to see the effects of a transferential investment other than in the form of maternal-type support. He was passive, showing reluctance to accept care but sensitive to the daily investment of caregivers. This opposition was largely overcome due to persistent efforts with support for all his activities and the implementation of therapeutic mediation (as with equestrian therapy) to foster the therapeutic link.

4. Discussion

These two clinical situations seem to us to illustrate the two forms of hikikomori that can be found in the literature, with the opposition between primary and secondary hikikomori (Kato et al., 2020).

The first instance is a transitional solution, a defensive modality in the face of the challenges that come when entering adulthood. The second form is much more damaging, freezing psychic functioning, preventing transformation and making any confrontation with others and with the outside world threatening. The two cases can be seen as illustrations of the two Japanese mythological figures of Amaterasu and Izanami.

From moderate to severe inhibition

The emergence of puberty, which initiates the adolescent process, mobilises an influx of excitement, due to bodily changes. These inevitably lead to an experience of passiveness which the adolescent will have to process. In an attempt to overcome this feeling, he will, sometimes frantically, resort to activity: to act so as not to feel acted upon by one's body, whose changes entail a confrontation with painful impotence. A privileged way of handling this is frequently to resort to action - especially in the case of boys - such as ordalic behaviour, behavioural disorders, etc.

On this basis, the claustration syndrome is an uncommon resort to process this excitement among male adolescents. Excitement is here considered as the energy that continually flows into the psychic apparatus. This apparatus is "*excitable*" both from outside and from within. In these adolescents, it is as if they had to neutralise any source of excitement. By isolating themselves, they manifestly avoid any outside solicitation - they literally lock themselves in. They massively avoid any type of encounter with others, any proximity with another body, be it pleasurable or associated with aggression, based on friendships, love interests or even sports related. "My room is my home. No-one can enter it. Even my mother coming in to clean it is infuriating" Augustin told us. He showed passive aggressive traits as described in the literature (Kastuki et al., 2019)

Inhibition takes on many forms, clinically as well as theoretically. It can relate to a symptom, a process or a defence mechanism, going from the normal to the pathological. Thus, while inhibition can be a non-specific symptom of pathology, it is above all a necessary modality to process excitation and regulate the quantity of instinctual energy. For example, one need only think of the inhibition of infantile sexual emotions, characteristic of entry into the latency period, when energy is directed towards other ends such as interest in learning and intellectual curiosity. Inhibition can be economically useful when the psychic apparatus risks being overwhelmed in its mental regulatory capacities.

Conceptually, inhibition unfolds as check against the *major functions of the ego,* i.e. sexuality, nutrition, movement and work. In this respect, inhibition can be understood as a form of sleep mode and an arrest in development. The ego can inhibit one of its functions in order to avoid conflict, especially where investment in that function is too strong (as with the inhibition of hunger in the case of anorexia nervosa).

While everyone transiently mobilises inhibition to handle tensions and mental conflicts, it becomes symptomatic when it hinders the subject's freedom, narrowing their scope of investment and action over the longer term: for example, while inhibiting thought processes is a common and harmless enough experience when transitory, it may become pathological when prolonged, barring the subject from any form of accomplishment.

Hikikomori can be understood as drastic inhibition when entering adolescence or adulthood. It may exhibit the characteristics of a symptom as it manifests a conflict between the desire of the adolescent and its impossible fulfilment. In economic terms, it is also a symptom due to its function in opposition to excitation. It tempers, moderates and prevents the tension relating to its accumulation. Inhibition is a curbing of the ego's functions.

In Hikikomori, inhibition is symptomatic, being expressed through the drastic limitation of the ego's functions, thus relinquishing all related, in particular motor (retreating in the bedroom), and sexual (essentially auto-erotic), pleasures. There is also an inhibition of relational investment. Clinical descriptions in the literature highlight the elaborate procedures for meals where, for example, food may be served on a tray at the bedroom door to avoid any contact. In most cases, motor activities and movements are reduced to a bare minimum. In a minority of hikikomori cases, moving outside the family environment is only possible after dark to avoid any possible encounters with others. Work and studies are, by definition, abandoned. Albert put an end to his involvement in a sport where he played at the highest level as also his schooling where he excelled. Augustin only left his bed to go to the adjacent bathroom but not to wash but rather to check in the mirror that he had not got fatter. This is very different from the

withdrawal of anorexic girls and boys to their rooms, which is usually accompanied by intensive physical exercise. However, very strong negative constraints can be observed in both situations, as described by T. Wooldridge (2016) in the case of anorexia nervosa in a boy who indulged in extreme physical activity to channel all forms of excitement.

None of the aforementioned articles address the sexual function and the matter still remains something of a conundrum. Besides traditional Japanese cultural prudery, there is here in the conceptual approach, a kind of scotoma that mirrors the suppressed or repressed sexual issue in hikikomori subjects. Adolescent sexuality is under genital primacy, whereas adulthood raises the issue of commitment to the couple and procreation. Sexuality and psycho-sexuality (in the sense of psychical excitation) are therefore highly mobilised during these stages of life. Withdrawal into the home holds these issues at bay.

Renouncing these major functions, that are a potential source of tremendous pleasure, helps reduce conflict. In response to instinctual outbreaks of arousal, withdrawal provides security against those who may generate invasive excitation. Thus, inhibition targets the instincts. This is sometimes part of a normal active process that limits the invasive functions of the ego. However, it can assume potentially pathological proportions with its risk of fixity and privileged resort to conflict avoidance. The duality of the concept of inhibition itself opens avenues of reflection on both types of hikikomori identified in the review of specialised works on the matter.

The first type involves adolescents and young adults whose mental processes are impaired. By withdrawing they seek to avoid anything that could arouse desire, anything that may push towards a quest for satisfaction outside oneself. To avoid depending on others for gratification and not risk being disappointed, these adolescents pull back. In this guise, inhibition marks a temporary suspension, a pause in the dynamics of the passage from adolescence to adulthood. Here, therapy can assist, providing that extra impetus to re-invest and open up to greater freedom for the ego.

Albert's relations with his mother were severely disrupted by her alcoholism and repeated suicide attempts. He described the anguish felt when returning from school to find her unconscious and having to hide the bottles to prevent his parents fighting. So, choosing to withdraw into his room had a defensive value against the demands of emotional and sensual drives and investment in relationships with others that could reactivate his feeling of insecurity. The gradual resumption of relationships in the mediated context of hospitalisation allowed him slowly to move out of this state of withdrawal.

In the second form of the syndrome, inhibition seems to be part of a pathological process that marks the impossible handling of excitation as source of anxiety. This leads to an interruption, rather than a suspension, of the process of adolescence. In some withdrawn adolescents, the power of projective emotion is such that the environment is perceived to be a threat, leading them to drastic phobic avoidance. Through a mechanism of projection, the external world seems to condensate all the internal contents that cannot be represented, but merely negatively experienced, encapsulating a series of threats. The menace that hovers over the ego due to the influx of excitement linked to the changes involved in puberty are projected outward. The other is seen as the cause of anxiety giving rise to an overwhelming sense of estrangement. Here the process of adolescence is jeopardised to the extreme.

For Augustin, the adolescent process was obstructed at the early age of 14. The bullying he suffered gave shape to his fears, under the guise of a threatening outside world. His parents were also considered a threat when they sought help due to their fears that their son would be incapable of surviving without their presence.

Both forms of hikikomori show an inhibition of the ego's functions. However, the notable difference between the two is that while on the one hand there is a transitory suspension of the adolescent processes, enabling their resumption after a pause, on the other there is a long term blocking of elementary functions, restraining investment, be it of the ego or in objects, depriving the subject of the freedom to work, think and love. Our hypothesis is that these two modes of hikikomori and self-confinement, as expressed in both types of the claustration syndrome, are two, more or less transient and massive, modalities of avoidance of confrontation with passivity.

Retreat as a struggle against passivity and as an attempt at figuration

Clinical cases of hikikomori and home-based claustration in the literature, as well as comorbidity studies, reveal two main similarities. The first relates to the population involved, namely a majority of adolescents and young adults (Lee et al., 2013; Wong et al. 2015). The second is the renunciation of solicitations and expectations from the outside world through a way of life marked by passiveness and withdrawal.

Activity and passivity designate the goals of the drive. Activity and passivity are expressed through behaviour but also in the fantasies that underlie that behaviour (sadistic and masochistic fantasies are a perfect example). There are strong oppositions between passive and active positions, determining the modalities of pleasure (in activity and passivity) but also object relations (relationships with others). Adolescence and its related burgeoning instinctual drives exert considerable strain on these different polarities.

On a manifest level, the first paradoxical opposition that stands out in hikikomori is that both activity and confrontation with the outside world are associated with displeasure, and are therefore to be avoided, while passiveness and withdrawal have pleasurable connotations. More latently, the prevalence of withdrawal reflects the importance of at all costs avoiding any confrontation with the limitations imposed by the outside world. By retreating to the bedroom, the adolescent evades the risk of being confronted with the impossible acknowledgment of his desires, that therefore only depend on others. This is a narcissistic position to avoid confrontation with a sense of helplessness, and the limitations and disappointments that inevitably arise when encountering others, different from oneself, and with their own independent desires. Augustin’s disappointment was overwhelming when at the age of 18, having gone out to Africa to seek his fortune, he had to be repatriated by the embassy, having in the space of two weeks lost all his money and all hopes of autonomy and dreams of greatness.

While these adolescents manifestly seem to find satisfaction in passivity, retreating and refusing to go out, they have actually taken a step towards a form of activity in locking themselves up in a retruse form of reality. Paradoxically, the claustration syndrome is a resort to acting *out*. The subject remains unaware that there is an internal stimulus pushing to act and repeat. With hikikomori this acting out might be considered as a “negative form of acting out”. This behaviour is the sign of a defence against a threat coming from a dual source, both external and internal.

In outside reality, the burden of constraints in Japanese and Western societies seems to be actively avoided through both home-based withdrawal and refusal of school or professional activities. Meanwhile, internal reality bears with it a much greater threat in the confrontation with an object that generates desire, and therefore, a dependency on objects and on the environment.

Passiveness is induced by excitation coming from others experienced as a threat, finding an outlet in resolutely resisting any new invasive desire. Boredom in the bedroom guarantees total rejection of any effects of excitation (De Luca, 2018). Upholding an immutable temporality is *acted out* by resorting to behaviour intended to abolish any expectation or desire and avoid any risk of dependency or disappointment. “Since my mother died, I'd rather be bored in my bedroom than being in school or with my friends who no longer understand me” as Albert put it.

Acting out as an attempt at figuration

Acts are indissociable from the body expressing them. *Acting out* mobilises a singular dynamic bringing together body and psyche. *Acting out* and acts are polysemous but more or less attest to

psychical suffering. Acts may take many forms and functions before being understood as a medium of communication: they can be signs before taking on linguistic form and figuration before symbolisation. Adolescence reactivates anxieties that oscillate between abandonment and intrusion, in a risk of confusion between affect, representation, thought and action. The intra-psychical and inter-psychical boundaries, meaning those within the psyche and those between Self and Non-Self, can no longer ensure their bridging functions and the effective flow of psychical movements. When the adolescent can no longer rely on sufficiently stable internal references, since those references are undermined by the changes of adolescence itself, the only solution left is to build more solid barriers in relation to material reality. Lacking any other defined foundation, the bedroom becomes the figuration of that internal space and its enclosed nature ensures a containing function. Resorting to action through withdrawal lies at the crossroads between psychopathology and nosography.

Our hypothesis is that for certain adolescents (first type), claustration is an attempt at figuration. Following the work of Cesar and Sara Botella (Botella & Botella, 2004), this attempt at figuration can be considered as a clinical manifestation of the failure or weakening of representation. For these authors, the work of figurability (*Darstellbarkeit*) represents a fundamental function of the psyche, referring to the passage from the unrepresentable to representation. This constitutes an intermediate medium between *acting out* and symbolisation. In this respect, for hikikomori individuals the materialisation of the space of containing and protection through the confined space of the bedroom is an attempt at figuration and creation of an individualised and effective *psychic* space. For Albert, the room is a place where he feels free: "my room is full of memories of my mother, I feel very calm, no-one bothers me, no one tells me what to do".

For these adolescents, resorting to a negative form of action (immobilism) could provide a form of containment and reception of excitation pending the means to process the related issues psychologically. In the case of hikikomori, we can hypothesise that the instability of internal objects requires the preservation of connection with external objects. Voluntarily staying at home can then be seen as an attempt to figure out and create a protective shield in material reality to compensate for deficiencies in the psychic apparatus. However, if this state of immobilisation were to persist, it would carry the risk of sterile repetition. For Albert, the fear of forgetting his mother explains his adamantly remaining in his room to continue conjuring up in his mind the tree where her ashes were scattered. The room thus represents the space where the bond with his mother persists, where he can continue to think of her without being distracted by other activities, other commitments. Keeping to the room is a materialisation of this faithfulness and lasting bond. The intensity of internal insecurity requires one to cling to material reality or even to certain perceptive aspects as with sight and smell.

In this second specific case, the outburst is such that it leads to the mobilisation of drastic projective defences. What cannot be processed mentally is massively directed outward, leading the sufferer in turn to become a persecutor. Such defence mechanisms provide an insight into the way hikikomori can have recourse to violence. Several such cases of aggressive behaviour made front-page news in Japan in the 2000s as with an attack on a bus, lethal assaults on parents, or on teachers or students in the same class. For Augustin, violence erupted when his father wanted him to leave his room to take part in a family meal to celebrate his elder brother's birthday. Only the walls of the room provided sufficient protection against the threat of intrusion and the break-in of object relationships.

Hikikomori: between depressivity and depression

Beyond the containment or immobilisation of excitement, claustration during the transition from adolescence to adulthood is also mobilised to confront loss and its associated perils. The mental processes harnessed in adolescence have to deal with the reactivation of loss that is inherent at that age with the loss of childhood and its paradisiacal vision, loss of omnipotent parental figures and loss of ideals. The narcissistic-objectal balance comes back into play against loss as a threat, especially when there is confusion between narcissistic investment and objectal investment. When narcissism is too weak, engaging with others is experienced as a risk of losing oneself rather than as a gain.

Albert insisted that after his mother's death he felt out of touch with his friends, who continued to have fun and failed to understand why he no longer wanted to spend time with them. Going through a process of mourning is a natural, necessary and healthy response when accompanied by a sense of perspective that offers future opportunities for emotional attachment. In contrast, when the loss of the object is mistaken for the loss of Self, the threat of annihilation becomes a reality and melancholy will prevail. Through withdrawal into one's bedroom, hikikomori adolescents limit or even cancel objectal confrontations and the threat they carry with them. This massive restriction of objectal relationships impoverishes the libidinal influx they bear with them. This impoverishment finds expression in a loss of energy that unfolds in two major patterns.

In the first pattern, libidinal collapse is limited and can be mobilised in keeping with the defensive suspension of psychic life, pending the narcissistic rehabilitation that could support moderate objectal relationships. This mirrors the contribution of P. Fédida (2001) on *depressivity*, which for him represents an ultimate humane capability. *Depressivity* is seen to be a way of weathering the storm, metaphorically hauling down the vessel's sails and affording protection to the whole psyche by reducing the overall sum of energy;

this is not clinical depression, but a depressive capability diminishing short-term commitment and, for example, leading to behaviour patterns such as hiding under the blanket or retreating into sleep to reduce tension and the weight of conflict. Withdrawal is then used constructively through removal from the commotion of the outside world, from the multiple objectal stimuli, due to an incapacity to confront them without suffering harm. Home-based claustration is a figure of the strategy of rarefaction of libidinal influxes. These adolescents leading their lives almost entirely in a single room reflects the containment of excitement that is filtered and restricted to what the psyche can actually handle. The protective shield function comes into play, processing fractions of libidinal energy, fragment by fragment. The inconstancy of the ego's boundaries, in the most vulnerable adolescents, contributes to frantic confusion when dealing with the object. The work on boundaries involved in the inside/outside delimitation and in modulation of the internal/external relationships is held back in its psychic dimension. The bedroom walls and the door become the essentials of material reality. Differentiation between interior/exterior is then significant and objectal transactions are restricted or simply confined to the parents. Through this extreme reduction of contact with the outside world, the adolescent shows a depressive behavioural pattern, but this is a ploy to rebuild the strength of an ego undermined by the adolescent process. Meanwhile, reactivation of oedipal issues informs relations with the parents, with threatening, sensual and aggressive undertones. The bedroom becomes a refuge preventing any close proximity with the parental figures, without however completely undermining recourse to an imaginary and fantasy life, a form of dormant psychic vitality.

Six months after his mother's death, Albert chose not to leave his room, ostensibly to allow his father to mourn. He gave up school and friends and all libidinal investments, as if this were necessary to temporarily maintain maternal objectal investment, despite her no longer being present. The boredom he experienced, indeed that he actively sought, seemed to be part of a desire to defer commitment.

The second pattern appears in adolescents whose psychic functioning is determined and who are unable to cope with the challenges of the adolescent process. Any confrontation with novelty - be it corporeal, relational, libidinal or objectal - can prove to be a source of anxiety, or even of distress and threat of ego collapse. The boundaries enclosing the Self become defensive walls as all energy is deployed to limit narcissistic haemorrhaging. The bedroom becomes a rampart against external invasion, but remains unable to protect against attack from within. These adolescents feel that they are being attacked from all sides. They become discouraged by the failure of claustration strategies and their refusal to connect with others and with the outside world.

Depressive collapse is part of the immobilisation of psychic dynamics. The weak narcissistic foundation does not provide the means to cope with the necessary processing of the instinctual burgeoning of puberty. In addition, failure of the work to create boundaries, as part of the internal/external delimitation, increases the confusion between subject and object. As in the melancholic process, distancing from the object, from its attack, or even its destruction, undermine the ego, as constructed by hikikomori adolescents. Indeed, the ego is demeaned, criticised and depreciated, thus creating a breeding ground for major depression. Adolescents withdraw into their bedroom because they cannot cope with what others think; feelings of shame and guilt for not meeting family and social expectations then lead to increased withdrawal. Peer group support, a common feature during adolescence, is impossible here due to lack of socialisation through school or extracurricular activities. The search for connections with other close relatives and adolescents, to share their distress, should be a high priority in the therapeutic process. Identificatory support is essential to rescue the extremely vulnerable ego of adolescents. Having recourse to virtual reality and online games is in keeping with such self-therapy. Given that online relationships are based on virtual media, they are less threatening and can therefore assist in therapeutic programmes.

Augustin seemed to be struggling with a melancholic process. He was born 20 years after his brothers, at a time when his mother had given up on having a daughter. The disappointment involved in this late pregnancy with the birth of yet another boy, contributed to a sense of negativity. Withdrawal into the bedroom froze libidinal investment and his whole life became arrested in a form of immobilism close to a form of death wish.

Recent studies (Chauillac et al., 2017; Ranieri & Luccherino, 2018) have described depressive symptomatology in both patterns, with different levels of severity.

Hikikomori as a way of dealing with personal, familial and societal ideals

The transition between adolescence and adulthood reactivates identification dynamics and confrontation with ideals.

Several researchers have posited cultural hypotheses that point to the refusal to integrate a sociocultural model that extols performance and labels those who are unable to comply with the standards as "losers". In that situation young people are tempted to stay at home and so avoid complete failure. These success-related issues reflect the anxiety and distress adolescents or young adults again experience when they engage in a process of separation from the parents.

In Japanese cases of hikikomori, as with our own subjects, the parents are the only contacts tolerated, with a greater closeness to the mother who sometimes stays at home with her child (De Luca, 2017).

This may be the effect of a prevalent identification with the omnipotent maternal figure. Home-based claustration then provides an opportunity to maintain a predominant narcissistic investment and identification with an infantile ideal ego that has not yet renounced its omnipotence.

Albert remained faithful to an idealised maternal image, far removed from the reality of his mother when she asked him to buy alcohol for her or hide the empty bottles. Withdrawal protected him from amorous advances. However, he was finally to succumb thanks to the protective environment of the hospital when he fell in love with a young girl who was also hospitalised.

Through seclusion, adolescents avoid the pain revived by the demands of the reality principle. Postponement becomes the rule as a means of fending off the confrontation with loss and castration to avoid the narcissistic wound resulting from failings and "later on" remains the watchword. Thus, the young adult freezes psychic temporality into an immutable form of functioning combined with confinement to a space (their bedroom) as an extension of their own narcissism.

The mother remains a dominant figure within a closed domestic space, with no opportunities to open out to otherness. Investment in the father is insufficient to take the risk of renouncing maternal investment and its concomitant fantasmic retaliation. The mother remains associated with an invincible omnipotent figure. For Augustin, staying in his room was a way of giving up on life, in an identification with this maternal figure, omnipotent but enshrined in a melancholic process. Articles devoted to studies of family dynamics stress the close bond between the mother and the young adult within the home as a closed space; any physical separation, seen to be a threat, is impossible to handle psychically. Given that high amounts of psychic energy are mobilised into an external objectal support to deal with the fleeting internal object, opportunities to engage in other forms of relationships such as romantic, friendly or professional relationships are limited. Such evanescence is the source of hikikomori withdrawal and inhibition issues. For both adolescents in our study, our findings concurred with those of Ranieri and Luccherino (2018) in seeing the hikikomori child serve as a support for the mother in managing anxiety.

Refusal of family and postmodern social values, both in Japan and in France, may provide the subject with a potential for construction. Hikikomori subjects are undoubtedly extremely fragile, imbued with the fear of losing their own selfhood to the benefit of the threatening ideals of the masses. Thus, their self-imposed lockdown points to an individual psychic temporality that prevails over the social time-scale, and an ideal ego that refuses to capitulate. Home-based withdrawal can be seen strategically to be an attempt at narcissistic reinforcement through the

avoidance of social dispersion or objectal expectations that may meet with disappointment. In caring for these young people, a gradual resumption of external contacts should be organised, confronting them with others so they can experience new and non-threatening experiences free of success-related challenges and based on reassurance. Confrontation with the outside and with others has to be mediated. Home care visits may help foster the introduction of a moderate level of exchange. However, in our experience, hospitalisation, which paradoxically offers another enclosed space to an adolescent who needs to break out, may offer a reassuring base for change and introduce a family dynamic in which separation is no longer merely internment with possible lethal undertones. The issues involved in the treatment of hikikomori are complex and there is no consensus in the literature (Teo, 2014). For some authors, long-term and active treatment is most effective (Li & Wong, 2015) especially when combining a clinical and a social approach (Chan & Lo, 2014). Individual, group and family care (Funakoshi & Miyamoto, 2014) is essential, as evinced in Ranieri and Luccherino (2018) and Frankova (2017) and therapeutic mediation as in Settineri (Settineri et al., 2019) can be seen to be beneficial. These approaches allow for the development of transferential links between different therapists, fostering a benign overall environment that can help the patient slowly emerge from withdrawal.

5. Conclusion

Since the first descriptions of the hikikomori phenomenon in Japan, the syndrome has become the subject of recent research works beyond the Japanese borders, questioning links between cultural issues and contemporary psychopathological forms of expression.

While withdrawal behaviours in adolescents are not new, the forms they take in hikikomori are singular enough for adolescence psychopathologists to grant special attention to them. From our perspective, alongside anthropological and phenomenological approaches, there is a need to consider the symptoms as a sign of the individual's psychic processing capabilities being overwhelmed. Like any other disorder in adolescence, it may turn out to be a transitional arrangement or the first sign of a psychopathological condition that may further develop and become more deeply rooted. We reassert the view that there is a continuum between the normal and the pathological. While a predictive approach appears remote, it is still important to improve our understanding of what is psychically mobilised in these adolescents who seem to lack the means to deal with conflicts other than by resorting to a symptomatic home-based withdrawal behaviour. In line with the research works by authors referenced in the bibliography and based on our own clinical experience working with adolescent patients and their families, we argue in favour of identifying two types of hikikomori. These two types were differentiated more on the basis of the underlying psychical conflicts than the symptomatic expressions encountered.

The first type of hikikomori inhibition is a transitional arrangement characterised by resorting to behaviour that supports figuration and symbolisation work. It serves the processing of identificatory conflicts to enable a more effective mobility between passive and active positions. Withdrawal is therefore a defence mechanism to suspend excitement, mobilising depressive capacities to cope with the demands of the ideal superego.

The second type is more severe involving drastic inhibition accompanied by paranoid anxiety and a real threat of morbid immobilism. Attempts at figuration fail to resolve the conflict leading to a vicious circle of total withdrawal. Fragile narcissism means that depressive collapse is a constant threat and there is a permanent risk of narcissistic haemorrhage. A ruthless and cruel ideal logic is deployed leading to self-punishment by banning any social or relational life.

Work will be further pursued to investigate the pointers to help differentiate between these two types from the perspective of intra-psychical functioning. The distinction allows for more targeted and effective care for the patients themselves and provides relief for the families.

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