Borderline personality disorder (BPD) is characterized by affective dysregulation and non-suicidal self-injurious behaviour (NSSI), which is closely linked with reduced pain perception. Several experimental studies revealed reduced pain sensitivity in BPD as well as significant correlations between pain perception, aversive inner tension and dissociation. Psychophysiological experiments revealed no deficit in the sensory-discriminative pain component in BPD. However, neurofunctional investigations point at alterations of the affective-motivational and the cognitive pain component in BPD. Preliminary evidence suggests that disturbed pain processing normalizes when patients stop NSSI after successful psychotherapeutic treatment. We could demonstrate that pain leads to a decrease in affective arousal and amygdala activity in patients with BPD and to an increase in amygdala-prefrontal connectivity. We are currently investigating the role of seeing blood and the importance of self-infliction of pain in the context of NSSI.

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S18

Neural pathways of the association between pain and suicide

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Physical pain and psychological pain are risk factors for suicidal behaviour, and understanding of the neural pathways linking pain and suicide may contribute to suicide prevention. Neuroimaging studies have shown changes in association with physical and psychological pain and with suicidal behaviour. Psychological stressors such as social exclusion may trigger emotional pain that is associated with functional changes in the prefontal cortex, cingulate cortex, thalamus, and parahippocampal gyrus. This functional network shows considerable overlap with brain areas involved in physical pain and suicidal behaviour. Changes in the brain motivation-valuation circuitry may predict pain persistence and thus contribute to the development of suicidal thoughts and behaviours.

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Culture-society bound psychopathology

S19

Hikikomori and modern-type depression in Japan

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Maladaptive social interaction and its related-psychopathology have been highlighted in psychiatry especially among younger generations. "Hikikomori" defined as a syndrome with six months or longer of severe social withdrawal was initially reported in Japan, and the prevalence rate has been reported as 1.2% in Japanese population. The majority of hikikomori patients are adolescents and young adults who become recluses in their parents' homes for months or years. They withdraw from contact with family, rarely have friends, and do not attend school or hold a job. An international vignette-used questionnaire survey indicates the spread of hikikomori in many other countries (Kato et al. *Lancet*, 2011; Kato et al. *Soc Psychiatry Psychiatr Epidemiol*, 2012). In addition, our international clinical studies have revealed the prevalence of hikikomori outside Japan (Teo et al., 2015). On the other hand, a novel form of maladaptive psychopathology, called modern-type depression has emerged in Japan (Kato et al. *J Affect Disord*, 2011; Kato et al. *Psychiatry Clin Neurosci*, 2016).

In this presentation, I will introduce "Hikikomori" and "modern-type depression" in Japan, and also propose novel diagnostic/therapeutic approach against them.

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S20

International research on social withdrawal

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Introduction Since the 1990s the term "Hikikomori" has emerged as a way to describe a modern form of severe social withdrawal first described in Japan. Recently, there have been increasing reports of Hikikomori around the globe.

Objectives To describe operationalized research criteria for Hikikomori, as well as epidemiologic, diagnostic, and psychosocial features of the Hikikomori in international settings.

Methods Participants were recruited from sites in India, Japan, Korea, and the US. Hikikomori was defined as a six-month or longer period of spending almost all time at home and avoiding social situations and social relationships, associated with significant distress/impairment. Lifetime history of psychiatric diagnosis was determined by the Structured Clinical Interview for the DSM-IV Axis-I and Axis-II Disorders. Additional measures included the Internet Addiction Test, UCLA Loneliness Scale, Lubben Social Network Scale (LSNS-6), and Sheehan Disability Scale (SDS).

Results Thirty-six participants meeting diagnostic criteria for Hikikomori were identified, with cases detected in all four countries. Avoidant personality disorder (41%), major depressive disorder (32%), paranoid personality disorder (32%), social anxiety disorder (27%), posttraumatic stress disorder (27%), and depressive personality disorder (27%) were the most common diagnoses. Sixty-eight percent had at least two psychiatric diagnoses. Individuals with Hikikomori had high levels of loneliness (UCLA Loneliness Scale M = 55.4, SD = 10.5), limited social networks (LSNS-6 M = 9.7, SD = 5.5), and moderate functional impairment (SDS M = 16.5, SD = 7.9).

Conclusions Hikikomori exists cross-nationally and can be assessed with a standardized assessment tool. Individuals with Hikikomori have substantial psychosocial impairment and disability, and a history of multiple psychiatric disorders is common.

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Diagnostic process in psychiatry

S21

Transcultural issues in diagnostic process

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Diagnostic systems and methods must respond to patients' diversity in expressions of mental distress, social and cultural context