on clinical staging and profiling of addictive behaviors combining neurobiological findings and clinical practice [6].

Disclosure of interest The author has not supplied his declaration of competing interest.

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S090

Clinical staging of psychotic disorders: From dimensions to neurobiology

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The clinical staging model is an approach used in medicine to define the extent of disease. In psychiatry, this model has recently been applied to psychotic disorders to distinguish the earlier, non-specific features of illness (e.g. ultra-high risk [UHR]; at-risk mental state [ARMS]), from later, more severe features associated with chronic illness. A key element of the staging model is to identify and classify the neurobiological processes underlying the disorder and to define potential interventions in the different stages. With the premise that dysfunctional neural mechanisms underlie symptomatology, the integration of categorical phenotypic classifications (class of disorder) with dimensional criteria (domains of dysfunction) becomes crucial. This approach aims to better classify trans-diagnostic dimensions of disease and discrete symptom-specific subgroup populations within biological frameworks, which may lead to the detection of new biomarkers and the development of more effective treatment and prevention strategies.

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Symposium: Mental health care in refugees and asylum seekers

S091

Providing care for migrants and refugees

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With growing globalisation and an increasing number of people on the move across boundaries, it has become vital that service providers, policy makers and mental health professionals are aware of the different needs of the patients they are responsible. One of the most fundamental barriers for migrants, refugees and asylum seekers in accessing health services are inadequate legal entitlement and, mechanisms for ensuring that they are well known and respected in practice. Access to the healthcare system is impeded by language and cultural communication problems. Qualified language and cultural mediators are not widely available, and moreover, are not regularly asked to attend. This can lead to misunderstandings, misdiagnosis and incorrect treatment, with serious consequences for the afflicted. The language barrier represents one of the main barriers to access to the healthcare system for people who do not speak the local language; indeed, language is the main working tool of psychiatry and psychotherapy, without which successful communication is impossible. Additionally, the lack of health literacy among the staff of institutions, which provide care for refugees and asylum seekers means that there is a lack of knowledge about the main symptoms of common mental health problems among these groups. The healthcare services, which are currently available, are not well prepared for these increasing specific groups. In dealing with ethnic minorities, including asylum seekers and refugees, mental healthcare professionals need to be culturally competent.

In this talk, main models for providing mental health care for migrants and refugees will be presented and discussed.

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S092

Cultural competence training and mental health care in refugees and asylum seekers

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Recent mass movement of human beings in various parts of the world has brought several challenges. Not only refugees from Syria and Libya to Europe but also refugees, migrants and asylum seekers in Latin America bring specific set of issues with them. It is critical that clinicians are aware of both the vulnerability of individuals to mental ill health as a result of migratory experiences but equally importantly their resilience. The impact on the mental health of those who may be involved directly or indirectly in delivering care along with those new communities who receive these groups need to be taken into account when planning and delivering psychiatric services. It is essential to recognise that experiences of being a refugee or asylum seeker are heterogeneous. Being an asylum seeker carries with it legal definitions and legal imperatives agreed at international levels.

Policymakers and clinicians need to be aware of differential rates of psychiatric disorders in these vulnerable individuals and specific needs related to language, religious values and other cultural factors. Mental health problems may be related to experiencing cultural bereavement where individuals feel that they have lost their cultures, relationships and cultural values. Judicious and careful use of trained culture brokers and mediators should be encouraged as these individuals can inform the team about community needs and inform the community about the team functioning and its principles so that community expectations can be managed appropriately. Such approaches may also help reduce stigma against mental illness.

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S093

Suicide risk in refugees and asylum seekers

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Increasing numbers of individuals forced to leave their home countries in areas of war, conflict, human rights violations and persecution pose a challenge for host countries to meet the mental-health care needs of these individuals. Refugees and asylum-seekers may face unique risk factors for mental disorder before, during, and after their migration leading to suicidality.

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Experiences of family withdrawal, integration difficulties, and perceived lack of care may contribute to suicide within the refugee populations. Identifying effective treatments and support to minimize the risk especially once the individuals arrive in their new country is key to providing appropriate care. Barriers to mental-health care including lack of knowledge about available resources, communication or language barriers, cultural beliefs about origins and treatment of mental disease, as well as a lack of trust in authority, pose a challenge for health care providers and policy makers.
Research has been inconsistent in the findings for the prevalence of mental disorders, suicidal behaviours, and suicide ideation among refugees and asylum seekers. Thus far, research has been limited to small scale, non-randomised, often qualitative analysis. Several studies have found higher rates of mental disorder, whereas others have found a similar prevalence as in the general population, although, Post-Traumatic Stress Disorder has more consistently been found to have a higher prevalence among migrants. The lack of early and thorough exploration of suicidal intent in this population requires large-scale quantitative studies to evaluate the effectiveness and feasibility of current practices in mental-health care and suicide prevention.
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Symposium: Reward processes in anorexia and bulimia nervosa: a new patogenetic model and future perspectives for treatment of eating disorders

S094

Functional connectivity of reward circuits in eating disorders

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Objective Anorexia nervosa display alterations of reward systems and some authors hypothesize the presence of a "starvation addiction". The aim of the study is to explore the resting-state functional connectivity of dorsal and ventral striatal nuclei.
Method 51 subjects with lifetime anorexia nervosa (AN) (35 acute and 16 recovered) and 34 healthy controls underwent high resolution and resting-state functional magnetic resonance imaging.
Results The AN group showed a reduced functional connectivity of the putamen in comparison to healthy women and this reduction appeared to be stronger in patients with lifetime binge eating or purging. Both acute and recovered AN groups showed larger left accumbens area in comparison to healthy women. Moreover, the functional connectivity of bilateral nucleus accumbens and putamen showed significant negative correlations with the number of obstetric complications in the AN group.
Discussion the present study supports the hypothesis that AN is associated with structural and functional alterations of striatal networks and unveils a possible role of obstetric complications in the pathogenesis of striatal dysfunction.
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S095

Emotional eating in eating disorders and obesity: Sensorial, hormonal and brain factors involved

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Obesity (OB) and eating disorders (ED) are two complex weight/eating conditions that share phenotypic traits, including psychopathological variables, specific environmental risk factors and biological vulnerabilities. Both OB and ED are associated with maladaptive eating styles that may be relevant to their development and maintenance. In abnormal/excessive eating behavior, a complex interplay among physiological, sensorial, psychological, social and genetic factors influence appetite, meal timing, and the quantity of food intake and food preferences. Neurobiological functioning has also been found to be altered in extreme weight conditions, namely with regards to reward processing, emotion regulation and decision making. In this presentation we will discuss the relevance of such components as well their interaction using findings from cross-sectional and longitudinal studies conducted in extreme eating/weight conditions, when compared with healthy controls. The development of innovative treatments considering neurobiological factors will also be covered.
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S096

Eating disorders and sexuality: A complex relationship

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Introduction The relationships between Eating Disorders (EDs) and sexuality are complex, and of interest for researchers and clinicians.
Objective To identify psychopathological and clinical factors associated with restoration of regular menses and sexual function in EDs patients.
Aims To evaluate the role of sexuality as a moderator of the recovery process after an individual Cognitive Behavioural Therapy (CBT).
Methods 39 Anorexia Nervosa (AN) and 40 Bulimia Nervosa (BN) female patients were evaluated by means of a face-to-face interview, self-reported questionnaires, including Eating Disorder Examination Questionnaire and Female Sexual Function Index, and blood sample for hormonal levels and biomarkers. The assessments were repeated at baseline, at one year follow up, and at three years follow up.
Results After CBT, both AN and BN patients showed a significant improvement of sexual functioning, which was associated with a reduction of core psychopathology. AN patients who recovered regular menses demonstrated a better improvement across time of psychopathological and clinical features, and were more likely to maintain these improvements at follow up. Recovery of regular menses and improvement of sexuality at the end of CBT were

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