assessment of both premature mortality (years of life lost–YLLs) and nonfatal outcomes (years lived with disability–YLDs). DALYs are computed by adding YLLs and YLDs for each age-sex-country group. In 2013, mental disorders contributed to 5.6% of total disease burden in EMR (1894 DALYS/100,000 population): 2519 DALYS/100,000 (2590/100,000 males, 2426/100,000 females) in high-income countries, 1884 DALYS/100,000 (1618/100,000 males, 2157/100,000 females) in middle-income countries, 1607 DALYS/100,000 (1500/100,000 males, 1717/100,000 females) in low-income countries. Females had a greater proportion of burden due to mental disorders than did males of equivalent ages, except for those under 15 years. The highest proportion of DALYs occurred in the 25–49 age group. The burden of mental disorders in EMR increased from 1726 DALYs/100,000 in 1990 to 1912 DALYs/100,000 in 2013 (10.8% increase). Depressive disorders accounted for most DALYs, followed by anxiety disorders. Palestine had the largest burden of mental disorders. Nearly all EMR countries had a higher mental disorder burden compared to global level. Our findings call for EMR health ministries to increase provision of mental health services and to address stigma of mental illness. Our results showing the accelerating burden of mental health are alarming as the region is seeing an increased level of instability.

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EW0155

Facial emotion recognition ability in psychiatrists, psychologist and psychological counselors

M. Dalkiran[1,*], E. Yuksek[2], O. Karamustafalioglu[1]
[1] *Sisli Hamidiye Etfal Hospital, Psychiatry, Istanbul, Turkey*
[2] *Viransehir public hospital, Psychiatry, Sanliurfa, Turkey*
* *Corresponding author.*

Objectives Although, emotional cues like facial emotion expressions seem to be important in social interaction, there is limited specific training about emotional cues for psychology professions.

Aims Here, we aimed to evaluate psychologist', psychological counselors' and psychiatrists' ability of facial emotion recognition and compare these groups.

Methods One hundred and forty-one master degree students of clinical psychology and 105 psychiatrists who identified themselves as psychopharmacologists were asked to perform facial emotion recognition test after filling out socio-demographic questionnaire. The facial emotion recognition test was constructed by using a set of photographs (happy, sad, fearful, angry, surprised, disgusted, and neutral faces) from Ekman and Friesen's.

Results Psychologists were significantly better in recognizing sad facial emotion than psychopharmacologists (6.23 ± 1.08 vs 5.80 ± 1.34 and $P = 0.041$). Psychological counselors were significantly better in recognizing sad facial emotion than psychopharmacologists (6.24 ± 1.01 vs 5.80 ± 1.34 and $P = 0.054$). Psychologists were significantly better in recognizing angry facial emotion than psychopharmacologists (6.54 ± 0.73 vs 6.08 ± 1.06 and $P = 0.002$). Psychological counselors were significantly better in recognizing angry facial emotion than psychopharmacologists (6.48 ± 0.73 vs 6.08 ± 1.06 and $P = 0.14$).

Conclusion We have revealed that the pyschologist and psychological counselors were more accurate in recognizing sad and angry facial emotions than psychopharmacologists. We considered that more accurate recognition of emotional cues may have important influences on patient doctor relationship. It would be valuable to investigate how these differences or training the ability of facial emotion recognition would affect the quality of patient–clinician interaction.

Keywords Facial emotion recognition; Psychiatrist; Psychologist; Psychological counselors

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EW0156

Family functioning, trauma exposure and PTSD in a middle-income community sample

S. Dorrington*, H. Zavos, H. Ball, P. McGuffin, A. Sumathipala, S. Siribaddana, F. Rijsdijk, S.L. Hatch, M. Hotopf
King's College London, Institute of Psychiatry, London, United Kingdom
* *Corresponding author.*

Introduction Only a minority of trauma-exposed individuals go on to develop post traumatic stress disorder (PTSD). Previous studies in high-income countries suggest that maladaptive family functioning adversities (MFFA) in childhood may partially ex-plain individual variation in vulnerability to PTSD following trauma. We test in a lower middle income setting (Sri Lanka) whether: (1) MFFA moderates the association between exposure to trauma and later (a) PTSD (b) other psychiatric diagnoses; (2) any moderation by MFFA is explained by experiences of interpersonal violence, cumulative trauma exposure or other psychopathology.

Methods We conducted a population study of 3995 twins and 2019 singletons residing in Colombo, Sri Lanka. Participants completed the composite international diagnostic interview, including nine traumatic exposures and a questionnaire on MFFA.

Results In total, 23.4% of participants reported exposure to MFFA. We found that (1) MFFA moderates the association between trauma exposure and both (a) PTSD and (b) non-PTSD diagnosis. (2) This was not explained by interpersonal violence, cumulative trauma exposure or other psychopathology.

Conclusions In our sample MFFA moderates the association between trauma and PTSD, and the association between trauma and non-PTSD psychopathology.

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EW0157

Kbg syndrome and the establishment of its neuropsychological phenotype

J. Egger[1,*], L. Van Dongen[1], C. Stumpel[2], E. Wingbermuehle[1], T. Kleefstra[3]
[1] *Vincent van Gogh Institute, Centre of Excellence for Neuropsychiatry, Venray, The Netherlands*
[2] *Maastricht University Medical Centre, Department of Genetics, Maastricht, The Netherlands*
[3] *Radboud University Medical Centre, Department of Genetics, Nijmegen, The Netherlands*
* *Corresponding author.*

Objective KBG syndrome is caused by a mutation in the *ANKRD11* gene, characterized by short stature and specific dental, craniofacial and skeletal anomalies. Scarce literature on the phenotypical presentation mention delayed speech and motor development as well as mild to moderate intellectual disabilities. As to psychopathology, often, autism and ADHD are mentioned but not yet substantiated in terms of neurocognitive variables.

Aim Aim of the current study was to investigate neurocognitive aspects of KBG syndrome.

Participants and Methods Seventeen patients (aged 6–66 years; ten females) with a proven ANKRD11 mutation were compared with two different groups of patients with a genetic disorder and similar developmental ages ($n = 14$ and $n = 10$). Neuropsychological assessment was performed focusing on the level of intellectual

functioning and on attention, memory, executive functioning, and social cognition.
Results In KBG patients, mild to moderate intellectual disabilities (WAIS IV Total IQ = 63.5 ± 10.7, range: 45–84) were established with a mental age that was lower than mean chronological age (6.4 ± 2.6 years versus 11 ± 5.7 years, respectively). When compared to both control groups, results indicated a relatively strong processing speed and social cognitive functioning of patients with KBG while direct recall of auditory memory was relatively poor most probably due to attentional dysfunction.
Conclusions The cognitive profile of this group of 17 patients with KBG is characterized by mild intellectual disability and diminished sustained attention in verbal tasks. Implications for diagnostic procedures and clinical management of the syndrome are discussed, also with regard to the question how this relates to classificatory diagnosis of ADHD.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EW0158

Deaf blindness and mental health – Prevalence of Mental disorders of an upper Austrian outpatient service

M. Fellinger[1,*], E. Sacherer[2], J. Fellinger[2]
[1] *Medical University of Vienna, Psychiatry and Psychotherapy, Vienna, Austria*
[2] *Hospital of St. John- Linz, Institute for Neurology of Senses and Language, Linz, Austria*
[*] *Corresponding author.*

Introduction People with deaf blindness are a vulnerable group concerning mental health problems. Due to their constraints in orientation, mobility, access to information and communication they often suffer from a lack of interpersonal relationships and accessibility to health care.
Aims To assess the prevalence of mental disorders in patients with deaf blindness and exam associations with forms of communication.
Methods A retrospective data evaluation of all outpatient charts of patients treated between 2000–2013 in a specialized outpatient unit that provides primary care for all deaf people for the whole catchment area of Upper Austria was conducted. Data were analysed regarding the degree of visual and hearing impairment and the presence of a mental disorder.
Results Forty-seven of 1500 patients were identified as deaf blind including 12 suffering from Usher Syndrome. Of those 29 (61.7%) were at least once diagnosed with a mental disorder, most frequently with a mood disorder (MD) (F30–F39) in 40.4%; an anxiety, stress-related, somatoform disorders (AD) (F40–F49) in 12.8% and a schizophrenia, schizotypal and delusional disorders (F20–F29) in 10.6%. Deaf blind patients suffered compared to deaf patients more often from a MD (40.4% vs.11.3%) however less often from a AD (12.8% vs. 32.6%). No significant association between the form of communication and being diagnosed with a mental disorder could be found.
Conclusion Patients with deaf blindness suffer to a high extend from mental disorders, especially MDs. It is of utmost importance to reduce the burden of this population and improve access to specialized services to diminish isolation as major risk factor.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EW0159

Anxious distress is associated with increased immune dysregulation in patients with major depressive disorder

R. Gaspersz[1,*], F. Lamers[1], G. Wittenberg[2], A. Beekman[1], A. van Hemert[3], R. Schoevers[4], B. Penninx[1]
[1] *VUMC, Psychiatry, Amserdam, The Netherlands*
[2] *Janssen Research & Development- LLC, Neuroscience, Raritan New Jersey, USA*
[3] *Leiden University Medical Center, Psychiatry, Leiden, The Netherlands*
[4] *University Medical Center Groningen, Psychiatry, Groningen, The Netherlands*
[*] *Corresponding author.*

Introduction Although depression with anxious distress appears to be a clinically relevant subtype of Major Depressive Disorder (MDD), whether it involves specific pathophysiology remains unclear. Inflammation has been implicated, but not comprehensively studied. We examined within a large MDD sample whether anxious distress and related anxiety features are associated with differential basal inflammation and innate cytokine production capacity.
Methods Data are from 1078 MDD patients from the Netherlands study of depression and anxiety. Besides the DSM-5 anxious distress specifier, we studied various dimensional anxiety scales (e.g. Inventory of Depressive Symptomatology anxiety arousal subscale [IDS-AA], Beck Anxiety Inventory [BAI], Mood and Anxiety Symptoms Questionnaire Anxious Arousal scale [MASQ-AA]). Basal inflammatory markers included C-reactive protein, interleukin (IL)-6 and tumor-necrosis factor (TNF)-α. Innate production capacity was assessed by 13 lipopolysaccharide (LPS)-stimulated inflammatory markers. Basal and LPS-stimulated inflammation index scores were created.
Results Basal inflammation was not associated with anxious distress in MDD patients (anxious distress prevalence 54.3%), except for modest positive associations for IDS-AA and BAI scores. However, anxious distress was associated with higher LPS-stimulated levels (interferon-ɣ, IL-2, IL-6, monocyte chemotactic protein (MCP)-1, macrophage inflammatory protein (MIP)-1α, MIP-1β, matrix metalloproteinase-2, TNF-α, TNF-β, LPS-stimulated index). Oher anxiety indicators (number of specifier items and anxiety diagnoses, IDS-AA, BAI, MASQ-AA) were also associated with increased innate production capacity.
Conclusions Within a large MDD sample, the anxious distress specifier was associated with increased innate cytokine production capacity but not with basal inflammation. Results from dimensional anxiety indicators largely confirm these results. These findings provide new insight into the pathophysiology of anxious depression.
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EW0160

Psychiatric disorders in adults with intellectual disabilities: A preliminary study of prevalence and associated factors

A. Görmez[1,*], K. İsmet[2]
[1] *Istanbul Medeniyet University, Psychiatry, Istanbul, Turkey*
[2] *Bezmialem Vakif University, Psychiatry, Istanbul, Turkey*
[*] *Corresponding author.*