ISSN 0924-9338

April 2019
Vol. 56S – pp. S1–S900

EUROPEAN PSYCHIATRY

THE JOURNAL OF THE EUROPEAN PSYCHIATRIC ASSOCIATION

Abstracts of the 27th European Congress of Psychiatry Warsaw, Poland 6-9 April 2019

89134

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EUROPEAN PSYCHIATRY
THE JOURNAL OF THE EUROPEAN PSYCHIATRIC ASSOCIATION

European Psychiatry (ISSN 0924-9338) 2019 (volumes 55-62) One year, 8 issues. See complete rates at http://www.europsy-journal.com
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Subscriptions – Tel.: (33) 01 71 16 55 99. Fax: (33) 01 71 16 55 77. http://www.europsy-journal.com
Publisher – Agnieszka Freda. Tel.: 0031612252117. E-mail: a.freda@elsevier.com
Journal Manager – Kheira Jolivet. Tel.: 33 (0) 1 71 16 50 21. E-mail: EURPSY@elsevier.com
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Imprimé en France par Jouve, 53101 Mayenne.
Dépôt légal à parution

ELSEVIER

Vol. 56, Supplement April 2019

EUROPEAN PSYCHIATRY

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Abstracted in: BIOSIS/Biological Abstracts, Current Contents/Clinical Medicine and Social & Behavioural Sciences, EMBASE/Excerpta Medica, MEDLINE/Index Medicus, PASCAL/INIST-CNRS, Psychological Abstracts, PsycINFO, PsyLIT, Research Alert, SciSearch

Abstracts of the 27th European Congress of Psychiatry - 2019

European Psychiatry 56S (2019) S1–S2

Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

Debate

D001

Con

Clinical/therapeutic: debate: sexual addiction: does it exist?

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It has been argued that compulsive sexual behavior (CSB) similar to pathological gambling (PG), meets the criteria for addiction. There is evidence showing that compulsive sexual behavior has the characteristics of addiction such as salience, mood modification, tolerance, withdrawal and adverse consequences. There are studies that have shown that exposure to visual sexual stimuli in individuals with compulsive sexual behavior is associated with activation of reward mechanisms similar to drug addiction. Cross-sectional studies report high rates of co-morbidity between compulsive sexual behavior and other psychiatric disorders such as depression, anxiety; Attention Deficit Hyperactivity Disorder (ADHD), obsessive–compulsive disorder (OCD) and personality disorders. However, despite many similarities between the features of hypersexual behavior and substance-related disorders there are gaps in our knowledge on compulsive sexual behavior and its treatment which precludes a definite conclusion that this is a behavioral addiction rather than an impulse control disorder. Therefore, more research is needed before definitively characterizing HD as an addiction at this time. This talk will review the empirical evidence and it will summarize the arguments against considering sexual addiction as a behavioral addiction (the cons side).

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

D002

Pro

Mental health policy: debate: do we need compulsory treatments in psychiatric practice?

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Mostly based on the results of the EUNOMIA study, still the largest prospective study on the use and outcomes of coercive measures (involuntary hospitalization, mechanical restraint, forced medication, seclusion) in general hospital psychiatry ever conducted, the presentation will outline that

1. Coercive interventions are a medico-legal and clinical reality in Europe, but show significant variation across countries; further, patients' views on involuntary hospitalization also differ across sites
2. There might be a link between the extent to which national mental health legislation protects patients' rights and the extent to which patients retrospectively evaluate that their involuntary admission was appropriate
3. Patients who feel coerced to admission may have a poorer prognosis than legally involuntary patients
4. Effective treatment of positive symptoms and improving patients' global functioning may lead to a reduction in perceived coercion
5. Caregivers' appraisals of involuntary inpatient treatment correlate with patients' symptom improvement

Conclusion.– If compulsory treatments in psychiatric practice are needed is an open question. Many aspects of the use of such interventions deserve deeper attention in research and clinical practice. The complexity of this field is such that simple pro-con answers are not possible. In general, we have to work on a standard of clinical practice guided by respecting autonomy and rights of our patients to the utmost.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

D003

Con

Mental health policy: debate: do we need compulsory treatments in psychiatric practice?

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I shall argue that involuntary treatment can be unnecessary in the practice of psychiatry. This is the position taken by a number of UN treaty bodies, including the UN Committee for the Convention on the Rights of Persons with Disabilities (CRPD), the UN Working Group on Arbitrary Detention and the UN Commissioner on

https://doi.org/10.1016/j.eurpsy.2019.01.004
0924-9338/

Human Rights. Other UN bodies' positions are less explicit about an absolute prohibition on involuntary interventions, but are framed in terms that support a central role for 'will and preferences', a key concept in the UN CRPD. They call for an urgent need to develop alternatives to coercive interventions. An important Resolution on Mental Health and Human Rights from the UN Human Rights Council calls upon States to "abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis" and to "provide mental health services for persons with mental health conditions or psychosocial disabilities on the same basis as to those without disabilities, including on the basis of free and informed consent".

I shall note the huge variation, twenty- to thirty-fold, between European countries in the use of involuntary treatment, implying unacceptable arbitrariness in its use. Attention will be drawn to the negligible research effort devoted to developing treatment approaches for the avoidance of coercive interventions. I shall then show how a focus on supportive measures aimed at enhancing patients' involvement in their care, together with a focus on respecting the person's 'will and preferences' would result in involuntary treatment becoming unnecessary.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

D004

Con

Mental health policy: debate: should the UHR paradigm for transition to mental disorder be abandoned?

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Current clinical high-risk (CHR) of psychosis criteria – particularly criteria relying on attenuated or transient positive symptoms and cognitive basic symptoms – are associated with conversion rates many times higher than the general incidence of psychosis. Yet, non-conversions still outnumber conversions, and CHR-relevant phenomena are not uncommon in the community, fueling an ongoing debate about their justification. This debate, however, widely disregards main general findings: persons meeting CHR criteria already suffer from multiple mental and functional disturbances for those they seek help; they exhibit various psychological and cognitive deficits along with morphological and functional cerebral changes, whereby, the majority of them fulfils general criteria for mental disorders; and beyond their association with subsequent psychotic disorders, CHR criteria do not specifically associate with any other mental disorder. Furthermore, while CHR symptoms might not be uncommon in the general population, CHR criteria almost as rare as psychotic disorders and, already at mere symptom level, are considerably associated with proxy measures of clinical relevance on community level, including low psychosocial functioning. Hence, the clinical picture defined by current CHR criteria might not be perceived only in terms of a psychosis-risk syndrome alone but rather as a psychosis-spectrum disorder in its own right with conversion to psychosis just being one and likely the worst of several outcomes and still the best available starting-point for an early detection of psychosis. Thus, the UHR paradigm clearly should not be abandoned but might rather act as a model for the early detection of other mental disorders.

Disclosure of interest.– The authors have not supplied a conflict of interest statement.

modulate or be modulated by sex hormones. Cortisol is the final mediator of the hypothalamic/adrenal/pituitary (HPA) response, and there is an elevation of cortisol in the normal stress response. Individuals with PTSD have low circulating levels of cortisol. Different types of traumas carry different risks for the development of PTSD, and there are also gender differences.
To examine gender differences in patients with PTSD.
Methods.– Study included 22 patients. Statistical analysis was performed.
Results.– Among patients were 12 man and 10 women. Lifetime prevalence of traumatic events was slightly higher in men than in women. The risk for PTSD following traumatic experiences was higher in women than in men. This gender difference was primarily due to women's greater risk of PTSD following events that involved assaultive violence. Women are more likely to have symptoms of numbing and avoidance and men are more likely to have the associated features of irritability and impulsiveness. Men are more likely to have comorbid substance use disorders and women are more likely to have comorbid mood and anxiety disorders. Duration of PTSD was longer in women than in men.
Conclusions.– There are gender differences in the prevalence and comorbidity presentation in PTSD in patients with PTSD. There are difference in the use therapy based on gender and comorbid diseases.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0841

Association between social anxiety disorder and posttraumatic stress disorder among a youth sample in lithuania

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Background and aims.– Social anxiety disorder (SAD) is prevalent among youth during emerging adulthood and are highly comorbid with other mental disorders, including posttraumatic stress disorder (PTSD). However, there is a lack of studies of comorbidity studies of anxiety and fear related disorders and stress-related disorders. The aim of this study was to assess prevalence of SAD and PTSD in the Lithuanian youth sample, and explore associations among SAD and PTSD symptoms.
Methods.– In total 590 undergraduate students of whom 67.6% were women aged 20 years on average participated in this study. The Social Phobia Inventory (SPIN) was used to measure social anxiety disorder symptoms. The Impact of Event Scale – Revised (IES-R) was used to measure PTSD symptoms.
Results.– 16.1% of all participants were identified as having a probable SAD diagnosis. 67.5% participants reported exposure to at least one life-time potentially traumatic event. Prevalence of probable PTSD was 17.5%. Life-time trauma exposure was not associated with SAD symptoms. SAD symptoms were correlated with PTSD symptoms. 32.2% of participants with SAD were also identified as having PTSD.
Conclusions.– We found high comorbidity of SAD and PTSD in a youth sample. These findings should be addressed in clinical practice in providing healthcare for young adults. Further studies are needed to explore comorbidity of social anxiety disorder with other mental disorders.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0842

Channel 4 dispatches program 'beyond belief' on satanist ritual abuse (SRA) in the UK – script review, follow-up and psychiatry implications

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Background and aims.– On 19 February 1992 Journalist Andrew Boyd presented a program concerning allegations of Satanist Ritual Abuse (SRA).
Snelling & Scott (1993) gave an account of the broadcast and response to the helpline for SRA Survivors.
This research aims to educate mental health professionals about the nature of SRA, the investigation complexities and cases that were successfully prosecuted.
Methods.– A 20-page typeset script was reviewed in the light of the 26 years that passed since the broadcast, by two experienced advocates.
Results.– Sara Scott, who ran the helpline, published in 2001 a book 'The Politics and Experience of Ritual Abuse: Beyond Disbelief' which details many disclosures of SRA including several dozen cases of 'Brood Mares', breeding babies for Satanist ritual human sacrifice.
A 'Cult' baby was born to the victim of convicted Satanist High Priest Colin Batley (2011).
Disgraced Lost Prophets singer Ian Watkins was sentenced (2013) to 35 years for a string of child sex offences including the attempted rape of a baby in a Satanist context.
Albert and Carolee Hickman once more received lengthy jail sentences (2015) in a historical SRA case that included 'sucking blood' after piercing the victim's finger with a bejewelled knife.
At least 10 SRA cases have been successfully prosecuted in Britain: http://casra.org.uk/prosecuted-cases/.
Furthermore, there is now official, public acknowledgement of the existence of SRA by the UK's largest and oldest police force, the Metropolitan Police Service: https://www.met.police.uk/advice/advice-and-information/caa/child-abuse/faith-based-abuse/.
Conclusions.– The research outlines avenues for further investigation and reminds mental health professionals of their duty to attend to each case on its own merits.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0843

Features of stress response in military actions participants with eye trauma and partial loss of vision

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Background and aims.– In the structure of modern military injuries, traumas of the visual organ occupy the second place by frequency. In Ukraine, by 2017, in the structure of ophthalmologic injuries as a result of a battle trauma, 52% are fragmental and other mechanical damages, which were not accompanied by massive craniocerebral trauma. Purpose. Studying the peculiarities of stress response and its role in development of psychological maladaptation and signs of

post-traumatic stress disorder in military actions participants with eye trauma and partial loss of vision.
Methods.– The research was carried out by clinical-psychological and psychodiagnostic methods. 216 people were examined.157 of them participated in military actions,102 got battle eye traumas with partial loss of vision. The comparison group: 59 people with partial loss of vision due to domestic eye traumas.
Results.– Eye trauma with partial loss of vision in military actions participants on the background of psychological maladaptation and signs of PTSD is accompanied by the development of state of frustration and severe neurotic stress response. The sources are personal limitations that arise from the trauma and lack of support from society, environment. The basis of the development of severe stress state in response to frustration are the phenomena of mental maladaptation. In its progress, maladaptation leads to neuroticism and somatization of the process against the background of preservation of general phenomena of maladaptation.
Conclusions.– This indicates the need to apply differentiated approach to neutralization of various sources of mechanisms of combined pathological process in planning measures for psychological correction of this category of victims.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0844

Posttraumatic stress and joint hypermobility syndrome among children and adolescents in selected schools of Nepal after the 2015 earthquakes

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Background and aims.– A substantial body of literature has recently addressed the connection between the exposition to a catastrophic event such an earthquake and the development of posttraumatic stress disorder (PTSD), especially in the vulnerable stratum of children and adolescents. However, little is known about its prevalence and risk factors. This study was undertaken 3–4 months after the 2015 earthquakes in Nepal, with the aim of providing new evidence to the field and documenting the role of a new potential predisposing factor: the joint hypermobility syndrome (JHS).
Methods.– 934 subjects from three different regions of the country, aged 8–18 years were assessed with self-completed questionnaires in a school-based cross sectional investigation. PTSD, as the response variable, was analyzed taking into account three subdimensions: the severity of symptoms, the severity of impairment, and both taken together.
Results.– The severity of PTSD in its three sub-dimensions was strongly predicted by the distance to the epicenter. Girls showed a higher affectation in the severity of symptoms field, but conversely a lower perturbation in the daily functioning dimension. Younger children reported a more severe functional impairment. JHS and non-JHS groups statistically differ in the prevalence of PTSD dual affectation, being the first more prone to suffer from it.
Conclusions.– The influence of the analyzed predisposing factors in the development of PTSD is discussed. Especially, the connection between JHS and PTSD is described with reference to the neuroconnective phenotype. It might be useful to consider the role of each variable when planning a mass intervention after a disaster.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0845

Differences in symptoms of insomnia between patients with PTSD and complex PTSD

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Background and aims.– According to recent data up to 80–90 percent of patients with PTSD experience insomnia and comorbid sleeping disturbances. Patients with sleep disorders are in higher risk of functional disability. Also their existing PTSD symptoms may exacerbate insomnia.
The aim of our study is to compare and identify differences between insomnia symptoms among patients with PTSD and Complex PTSD and to better understand Complex PTSD.
Methods.– This study among 100 patients with PTSD and Complex PTSD is a part of other project about correlation of stress exposure, presence of PTSD symptoms and inflammatory markers connected with some somatic diseases.
Diagnosis of Complex PTSD based on results of: "International Trauma Questionnaire". Insomnia symptoms measured by: "Insomnia Severity Index".
Results.– Reliving the trauma through "flash backs" and nightmares may lead to hyper-arousal, avoiding going to bed and worsening insomnia symptoms in patients with Complex PTSD.
So we expect more severe symptoms of insomnia in these patients.
Conclusions.– Current PTSD diagnosis often does not fully capture the severity of psychological harm that occurs with prolonged, repeated trauma, such as:changes in self-concept and adaptation skills, addictive behaviour, self-mutilation. ICD 11 identifies this condition as a separate diagnosis that includes PTSD with personality changes and named it: "Complex PTSD".
Complex PTSD is still often misdiagnosed as personality disorder or unrecognized. We hope this study will help to improve this.
Disclosure of interest.– The authors have not supplied a conflict of interest statement.

E-PP0846

Multimodal-psychological rehabilitation combatants in Ukraine

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Background and aims.– For the period of 2014–2017 years, the specialists of the department of psychotherapy of the KMAPE conducted consultative-diagnostic, medical and psycho-rehabilitation assistance to 2,387 demobilized participants of the ATO, including on the basis of the Clinical sanatorium "Resort Berezovsky mineral waters" - 650 persons, in the "Regional hospital of war veterans" - 130 persons, as a part of visiting polyprofessional brigades on the bases of the Central district hospitals of the Kharkiv region - 1607 persons. The principle of the formation of the psychological rehabilitation of persons involved in the implementation of the ATO should be the demarcation of contingents, on which depends the mobilization route of the participants of the ATO. The first group is demobilized persons whose combat stress did not lead to mental and behavioral disorders that reach a painful level.