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

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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

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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

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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