In this presentation, we will consider the evidence for comorbidity between ASD and addiction [substance use disorders (SUD)] and explore the possible underlying explanations.
Methods A literature study on similarities between addiction and ASD (at a phenotypical and neurobiological level) as well as a case note review on a year cohort of 120 consecutive admissions in an adult addiction psychiatry unit and 120 admissions in an adult ASD unit.
Results In our addiction psychiatry cohort, 8 (men) on 118 patients were diagnosed with autism spectrum disorder. This is much higher than in the general population (1%). In the ASD cohort, the results are measured at the moment and the results will be presented in the presentation.
Autism spectrum disorders and addiction can both be perceived as developmental disorders in which a genetic predisposition and vulnerability interact with environmental factors. They can be induced by early stress thus affecting the proper functioning of the cortico-striatal dopaminergic regulation systems (and also the HPA axis). In "pure" ADHD this is attributed to a deregulation in the cognitive loops and the "impulsivity" endophenotype. Whereas in cases of ASD without an ADHD component the limbic and sensimotore cortico-striatal regulations loops are also involved.
Conclusions There are clear indications that a possible comorbidity of substance abuse disorder should be considered in cases of individuals with autism spectrum disorders. This finding is important for clinicians to take into account in assessing patients with addiction problems and ASD.
Disclosure of interest The author has not supplied his declaration of competing interest.

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Coercion in psychiatry: Challenges and perspectives

S14

Ethical challenges in the use of coercion

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The use of coercive measures remains one of the great challenges in psychiatry.
Increased focus on patient rights and autonomy, concern from user and relatives organizations as well as from human rights organizations all have contributed to that the use of all kinds of coercion is high on the agenda. And yet, we are still faced with that a number of psychiatric patients will experience that coercive measures are used as part of their treatment.
The EPA Ethical Committee carried out a survey comprising the European associations of psychiatry in which a questionnaire was circulated regarding what the different associations found were the major ethical challenges in their respective countries.
Among the issues that have given rise to particular concern are the use of physical restraints including why some countries avoid physical restraints while other – e.g. Denmark – use it extensively. Why do we find such large differences? Is this due to different approaches to coercion, different traditions? Shortage of resources?
Another concern is that certain groups seem more likely to be subject to coercion compared to others. Thus, it has been demonstrated that patients belonging to ethnic minority groups are more likely to experience this.
The paper will focus on ethical problems and issues of concern related to the use of coercion. The focus will be on facets of international relevance with the aim to remain critical towards the use and when needed to strengthen the quality of coercive treatment care.
URL: http://www.mariannekastrup.dk
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S15

Does the use of coercion improve the outcome of patients with severe mental disorders?

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Coercive measures have always been part of the psychiatric armamentarium; however, the clinical and ethical dilemma between the use of a "therapeutic" coercion and the loss of patients' dignity is one of the most controversial issues in mental health practice. According to International guidelines, coercive measures should be adopted only when all the other less restrictive approaches failed and should be considered as the "last restrictive alternative". Although coercive measures are frequently used to manage patients' aggressive behaviors and self-harm, refusal of medication and impulsivity, their effect on patients' outcome is not clear. In fact, the use of coercive measures can reduce patients' aggressiveness and improve psychiatric symptoms, but can also have a negative impact in terms of therapeutic relationship, engagement with mental health services and self-stigma, arising negative feelings on patients and on mental health professionals. International attempts have been made to improve and harmonize the use of involuntary treatments. Recommendations of good clinical practice on the use of coercive involountary treatments and forced medications have been proposed by the EUNOMIA consortium, and the effect of coercion on the outcome of patients with severe mental disorders have been described. Results of this study will be reported as well as lessons learnt from other international experiences.
Disclosure of interest The author has not supplied his declaration of competing interest.

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Considering pain to better understand the suicidal process

S16

Psychological pain and interpersonal theory of suicide

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Psychological pain is an important variable in the understanding of suicidal individual.
This presentation describes the how psychological pain interacts with problems in communication to set up risk for serious suicidal behavior and describes some empirical studies supporting a model for using this concept in suicide prevention strategies.
Disclosure of interest The author has not supplied his declaration of competing interest.

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S17

Pain perception in self-injurious behaviours

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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.

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

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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