explore this territory. Qualitative, narrative data from parents and children on the liver-transplant service already supports the advantage of parents’ capacity to tolerate their own anxiety enough to be able to hold their child’s mind in their minds, including their child’s own fears of annihilation, regression, and body disintegration so as to optimize a good-enough alliance with the health-care team, improve medical compliance, a hopeful outlook, and thus more positive physical and mental health outcomes.

Discussion.– Indeed, the application of psychoanalytical principles and technique within the pediatric hospital setting is far from the practice of classical psychoanalysis on a couch in a comfortable furnished office. Nevertheless its theoretical foundation seems very helpful in dealing with complex clinical cases such as that which we have described above. It also informs and helps our reflection upon original research that delves deeper into the psychology of children and adolescents, some already at significant psychiatric risk even before their medical issues become apparent, who go on to suffer life-threatening chronic illness.

http://dx.doi.org/10.1016j.neurenf.2012.05.387

**Child psychiatry in pediatric palliative care**

Tu-S-414

**La spécificité de la pédopsychiatrie de consultation-liaison en soins palliatifs**

M. Vadnais a,*, P. Canouib

a Service de psychiatrie, hôpital Sainte-Justine, Montréal, Canada

b Service de psychiatrie, hôpital Necker–Enfants-Malades, Paris, France

*Auteur correspondant.

Le rôle du pédopsychiatre qui œuvre au sein d une équipe de soins palliatifs pédiatiques (SPP) est vaste, et va bien au-delà de la pharmacothérapie, qui demeure toutefois un outil indispensable. La consultation auprès de l’enfant et sa famille permet l’évaluation des réactions anxio-dépressives, de normales à pathologiques. Le pédopsychiatre fait face à des enjeux ethniques autour du consentement/refus de traitement, les aspects médico-légaux se compliquant si la maladie ou l’invalidité s’est manifestée tardivement, la vie même de l’enfant est en jeu. Sa fonction est antérieure à la maladie, mais est englobée à ce moment-là dans le processus diagnostique. Il est le troisième membre d’une équipe de soins qui se compose du pédiatre et du praticien en soins palliatifs. Ceci est essentiellement un processus de soutien à la vie, à la qualité de la vie, à l’existence même de l’enfant.

Le traitement de l’invisibilité de la maladie, la prise en charge de la douleur, de la gêne, du désespoir, de la mort, de la mort imminente, de la vie et de l’espérance fait partie intégrante de la mission du pédopsychiatre qui travaille au sein d’équipes de soins palliatifs, en coopération avec le reste de l’équipe médicale, mais aussi avec les membres de la famille.

http://dx.doi.org/10.1016j.neurenf.2012.05.388

**What is the specific child psychiatrist’s role in pediatric palliative care nowadays in France?**

M. Vignesa

Service de Psychiatrie de l’Enfant et de l’Adolescent, CHU de Toulouse, France

The treatment of severe children’s disease has changed, cares are given faster and faster in hospitals and children who are included in palliative care programs are more of the time at home. Consequently, the role of a child psychiatrist in a palliative care team is quite different from what it was ten years ago, when the pediatric palliative care team first started to work in Toulouse Children’s Hospital. He has to face “emergency situations” like unexpected death of babies and to be ready to visit the child and his family out of the hospital, at home or in a Children’s hospice.

He must be able to meet the siblings before and after the bereavement. He is involved in support programs for home care teams and has to listen attentively to the others caregivers (nurses and paediatricians). However, he also has to meet young patients weekly or more during specific consultations, where the fatal issue is discussed and sometimes has also to prescribe psychotropic drugs when necessary.

http://dx.doi.org/10.1016j.neurenf.2012.05.389

**Face processing in ASD**

Tu-S-415

**Studying face processing in autism through the interplay between high and low level visual processes**

B. Jemel a, Y. Zérouali

Laboratoire de recherche en neurosciences et électrophysiologie cognitive, hôpital Rivière-des-Prairies, Montreal, Canada

*Corresponding author.

There is now converging evidence that dynamic interactions between low and high visual processes as well as functional coupling of neural discharges within distributed cortical networks can account for key properties of conscious visual experience. In the present presentation, we show that a defect in these neurofunctional processes may be central to understanding certain cognitive dysfunctions/typicalities in autism (i.e. superior processing of low-level perceptual inputs, difficulty processing cognitively complex materials such as faces). We present behavioral and electrophysiological evidence from different paradigms that demonstrate that visual perception of facial stimuli in young adults with high functioning autism (HFA) is less biased by task instructions, is less finely tuned to relevant visual information, is not modulated by subjective perception in response to bistable images (i.e. can be perceived as either faces or objects), and results from locally integrated neural information as revealed by an EEG synchrony study.

http://dx.doi.org/10.1016j.neurenf.2012.05.390

**Processing emotion and gaze direction of fearful faces in children with autistic disorders**

J.-M. Guié a,*, H. Droulinb, E. Ronneau, M. Bon St-Come, P. Berquin d, A. Hoein c, R. Millet b, B. Jemel d, L. Vandrommee, C. Mille a

a Service de psychiatrie, CHU Amiens-Picardie, Amiens, France

b Service de psychiatrie, hôpital Rivière-des-Prairies, Montreal, Canada

c CRA, Amiens, France

d HRDP, Montreal, Canada

e Laboratoire d’ électrophysiologie, HRDP, Montreal, Canada

*Corresponding author.

Adults without Mental Disorders (Pourtois, 2004) and typically developed (TD) children (Hoehl, 2010) demonstrated attentional bias towards fearful faces. Threat-cued stimuli tend to capture attention more rapidly than neutral faces, thus eliciting an involuntary orienting of spatial attention towards the probe’s location. In addition to the facial cue’s emotional content recent studies (Akechi, 2010; Senju, 2008) have brought questions about the role of the gaze direction. Objectives.– The present study investigated spatial orienting towards fearful faces in children with Autistic Disorder using reaction times (RTs) while controlling for gaze direction.

Methods.– Following a feasibility study, eleven 6–11 year-old children with an Autistic Disorder ADOS and ADI-based diagnosis were recruited alongside with age-matched TD participants. The experiment, previously used with normal adults by Pourtois et al. (2004) and adults with High Functioning Autism (HFA) by Jemel et al. (Giraud, 2008), was adapted to include a baseline evaluation of visual attention capacities and the testing of both direct and averted gaze conditions. Each trial consisted of a 100 ms-presentation of a pair of faces (one fearful and one neutral) briefly followed by a Teddy bear unilaterally presented at the location of one of the faces. Participants were asked to press a response-key on the side of Teddy bear’s presentation. RESULTS In the Autistic Disorder group, longer RTs were significantly (P<.05) associated with the probe’s presentation at the location of the fearful face. With respect to the averted vs direct gaze...