women. Furthermore, some women participating in PP also report being coerced into unwanted sexual acts. Therefore, featuring in a PP could be experienced as a traumatic event, and could be associated with negative mental health disorders.
Objectives: Our study examines mental health indicators among Women who have participated in at least one PP (WPP), and who consulted clinical psychologists, after referral by WPP support groups.
Methods: Thirty-six women were recruited by two clinical psychologists during an individual consultation. Participants completed the French versions of the post-traumatic stress disorder (PTSD) Checklist for DSM-5 (PCL-5), the Dissociative Experiences Scale (DES), as well as the 13-item Beck Depression Inventory (BDI-13). Data on socio-demographic characteristics, lifetime experience of sexual violence prior to participating in a PP, as well as the perceived effect of participating in a PP were also measured.
Results: The mean age of participants was 31.2 (std=7), and the average age at first participation in a PP was 23.4 (std=6). The majority (78%) of participants reported lifetime experience of sexual violence prior to participation in a PP. Thirty women (83%) had a PCL5 score over 33 indicative of probable PTSD, and 28 women (78%) had a DES score of 30 or more indicating high levels of dissociation. Further, 16 participants (44%) reported a BDI-13 score over 16 indicating severe depression.
Conclusions: This study highlights the high prevalence of PTSD, dissociative experiences, and depressive symptoms in a clinical population of women who featured in at least one PP. Further studies are needed to better understand the scale of the problem and optimize care interventions.

Disclosure of Interest: None Declared

EPP0511

Randomized Controlled Trials to Treat Obesity in Military Populations: A Systematic Review and Meta-Analysis

D. Gravina[1,2*], J. L. Keeler[1,3], M. N. Akkese[1], S. Bektas[1,4], P. Fina[5], C. Tweed[3,6], G. D. Willmund[7], L. Dell'Osso[2], J. Treasure[1,3] and H. Himmerich[1,3]

[1]Institute of Psychiatry, Psychology and Neuroscience, King's College London, Centre for Research in Eating and Weight Disorders, London, United Kingdom; [2]University of Pisa, Department of Clinical and Experimental Medicine, Pisa, Italy; [3]Bethlem Royal Hospital, South London and Maudsley NHS Foundation Trust, London, United Kingdom; [4]Hacettepe University, Department of Psychology, Ankara, Türkiye; [5]Sigmund Freud University Vienna, Faculty of Psychology, Vienna, Austria; [6]Royal Navy Reserve, London, United Kingdom and [7]Military Hospital Berlin, Bundeswehr Center for Military Mental Health, Berlin, Germany
*Corresponding author.
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Introduction: In recent years, overweight and obesity have reached an alarmingly high incidence and prevalence worldwide; they have also been steadily increasing in military populations. Military personnel as an occupational group are often exposed to stressful and harmful environments that represent a risk factor for disordered eating with major repercussions on both physical and mental health.
Objectives: This study aims to explore the effectiveness of weight loss interventions and to assess the significance of current obesity treatments for military populations.
Methods: Three online databases (PubMed, PsycInfo, and Web of Science) were screened to identify randomized controlled trials (RCTs) aiming to treat obesity in active-duty military personnel and veterans. Random-effects meta-analyses were conducted for body weight (BW) and body mass index (BMI) values, both longitudinally comparing treatment group from pre-to-post intervention, and cross-sectionally comparing the treatment group to controls at the end of the intervention.
Results: A total of 21 studies were included: 16 cross-sectional (BW: n=15; BMI: n=12) and 16 longitudinal (BW: n=15; BMI: n=12) were meta-analyzed, and 5 studies were narratively synthesized. A significant small overall BW and BMI reduction from baseline to post-intervention was observed (BW: g = -0.10; p = 0.015; BMI: g = -0.32; $p < 0.001$), together with a decreased BMI (g = -0.16; p = 0.001) and nominally lower BW (g = -0.08; p = 0.178) in the intervention group compared to controls at post-intervention time-point. When conducting additional meta-analyses dividing by sample type, a significant decrease in both BMI (g= -0.35; p< 0.001) and BW (g= -0.12; p= 0.041) from pre-to-post intervention was observed in active-duty military personnel but not for veterans.Recommendations for clinical practice have been outlined from the findings of this study and summarized in Figure 1.
Image:

Topic	Clinical recommendations	Practical implications	Level of evidence	RCTs (n)
Short-term weight loss intervention for obesity (up to 6-12 months).	Individual or group-based comprehensive lifestyle intervention	Physical activity (aerobics, resistance or high intensity); no sufficient evidence from RCTs regarding a superior effectiveness of one type, frequency, or intensity of physical activity.	High	18
		Dietary and nutritional interventions such as meal replacements promoting low caloric balance intake and healthy meal plans provided by a registered dietitian (when available) and individualized to each patient.	High	12
		Cognitive behavioral therapy, psychoeducational strategies, and motivational techniques for cognitive, emotional, and social factors that influence weight management.	High	12
		Structured outcome monitoring over time (clinical or self-monitoring): body weight, BMI, fat percentage, waist-to-hip ratio, abdominal circumference.	High	12
		Internet-based intervention when in-person programs are not available.	Good	5
		Behavioral therapy plus use of technology (e.g., pedometer).	Weak	2
		Pharmacological intervention (e.g., Orlistat).	Weak	1

Conclusions: Despite limitations, such as the heterogeneity across the included interventions and the follow-up duration, our findings highlight how current weight loss interventions are effective in term of BW and BMI reductions in military populations, and how a

comprehensive approach with multiple therapeutic goals should be taken during the intervention.

Disclosure of Interest: None Declared

EPP0512

From guided self-help to comprehensive ED treatment

B. Babusa[1], K. Bai-Nagy[1]*, J. Kovács[1], Á. Dósa[1], G. Salavecz[1], F. Túry[1] and G. Purebl[1]

[1]Semmelweis University, Faculty of Medicine, Institute of Behavioural Sciences, Budapest, Hungary
*Corresponding author.
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Introduction: The incidence of eating disorders is increasing in Hungary and Central-Eastern Europe. The number of complex/severe cases is also increasing. Accordingly, several new unmet needs of the users and their relatives appear in the clinical care.
Objectives: As a possible response to these unmet needs, we have introduced a multifaceted care model for eating disorders. To facilitate easily accessible yet effective care close to home, a support programme with an online guided self-help tool and regular consultations with first responder psychiatrists or clinical psychologists has been introduced. For non (or partial) responders, a multifaceted modular treatment programme has been developed with an individualised combination of different therapeutic approaches, including family therapy, dialectical behaviour therapy (DBT) specific to binge eating disorder and bulimia, CBT and the use of virtual reality as an adjunct treatment. The most severe cases are referred for (also multifaceted) inpatient treatment. In terms of research, we want to focus on the key issues for rapid, cost-effective treatment. Firstly, we want to develop an individual profiling system at the start of therapy to assess which individual combination of modules can produce a rapid therapeutic response. Secondly, we want to identify the active gamechanger elements of therapy that are associated with the greatest change in symptoms.
Methods: Patients complete the following questionnaires:
-in the guided self-help group: Eating disoreder inventory, (EDI-I), McMaster Family Assessment Device (FAD), Eastin Disorder Diagnostic Scale (EDDS), Eating Behavioral Severity Scale, Eating Disorders Symptom Impact Scale (EDSIS-S)
- in DBT groups: Eating Disorder Examination Questionnarie (EDE-Q), Three Factor Eating Questionnaire-R21, Rosenberg Self-Esteem Scale, Patient Health Questionnaire-(PHQ-9), Cognitive Emotion Regulation Questionnaire (CERQ)
- in individual therapies: Mini International Neuropsychiatric Interview (MINI) and Structured Clinical Interview for DSM 5- Alternative Model for Personality Disorders (SCIP-5-AMPD), EDI-I., Mentalization Questionnaire (MZQ), Dissociation Questionnaire (DIS-Q), Symptom Checklist-90 (SCL-90), (PHQ-9), Childhood Trauma Questionnaire (CTQ) and Young Parenting Inventory (YPI).
Results: Patient recruitment and therapies are currently underway, the first preliminary results are expected in the spring period.
Conclusions: In order to provide individualized care more effectively, it is important to identify the factors that determine which therapeutic modalities work best for the patient.

Disclosure of Interest: None Declared

EPP0513

Association between childhood maltreatment and cortical folding in women with eating disorders

R. Cerra[1]*, N. Attianese[1], M. Battipaglia[1], R. Ceres[1], S. Donato[1], A. M. Monteleone[1], P. Monteleone[2] and G. Cascino[2]

[1]Department of Mental, Physical Health and Preventive Medicine, University of Campania "Luigi Vanvitelli", Naples and [2]Department of Medicine, Surgery and Dentistry, University of Salerno "Scuola Medica Salernitana", Salerno, Italy
*Corresponding author.
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Introduction: Childhood maltreatment (CM) is associated with distinct clinical and biologi- cal characteristics in people with eating disorders (EDs). The measurement of local gyrification index (lGI) may help to better characterize the impact of CM on cortical structure.
Objectives: The objective of this study was to investigate the association of CM with lGI in women with EDs.
Methods: Twenty-six women with anorexia nervosa (AN) and 24 with bulimia nervosa (BN) underwent a 3T MRI scan. All partici- pants filled in the Childhood Trauma Questionnaire. All neuroimaging data were processed by FreeSurfer. LGI maps underwent a general linear model to evaluate differences between groups with or without CM. People with AN and BN were merged together.
Results: Based on the Childhood Trauma Questionnaire cut- off scores, 24 participants were identified as maltreated and 26 as non-maltreated. Maltreated people with EDs showed a significantly lower lGI in the left middle temporal gyrus compared with non-maltreated people, whereas no differences emerged in the right hemisphere between groups.
Conclusions: The present study showed that in people with EDs, CM is associated with reduced cortical folding in the left middle temporal gyrus, an area that could be involved in ED psychopathology. This finding corroborates the hypothesis of a 'maltreated ecophenotype', which argues that CM may allow to biologically, other than clinically, distinguish individuals with the same psychiatric disorder.

Disclosure of Interest: None Declared

EPP0514

The Portuguese version of the Screen for Disordered Eating: Validity and reliability in the perinatal period

A. T. Pereira[1], R. Lima[2], J. M. Pinto[1], D. Pereira[1], A. Macedo[1], C. Marques[1], A. I. Araújo[1], B. Barbosa[2] and C. Pinto Gouveia[1]*

[1]Institute of Psychological Medicine and [2]Faculty of Medicine, University of Coimbra, Coimbra, Portugal
*Corresponding author.
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Introduction: Despite the increased knowledge about the prevalence and consequences of eating disorders (ED), they continue to be underdiagnosed and undertreated. Being more common in women of childbearing age, the perinatal period may play a decisive role in the incidence and course of these pathologies. The Screen for Disordered Eating (SDE) was developed for the screen of ED in primary care.