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Are mother-baby units the standard of care for the treatment of postnatal mental health disorders

C. P. Desport[1]* and R. F. Dionísio[1]

[1]Hospital de Magalhães Lemos, Unidade Local de Saúde de Santo António, Porto, Portugal
*Corresponding author.
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Introduction: The postpartum is a high-risk period for onset and recurrence of maternal mental health disorders. If left untreated these disorders can have important consequences on mother, baby and family. When the disorder is severe or there are no conditions to manage it in the community the mother may need to be hospitalized and the gold-standard are the mother-baby units (MBU) in which mothers are co-admitted with their infant.
Objectives: We aim to explore this model of care (MBU), the pros and cons and how it has been done worldwide, so you can better understand how they work and improve the care we provide to our patients.
Methods: To this purpose we conducted a literature review by searching and analyzing papers on mother-baby units. The search was on PubMed and Google Scholar, with the following key-words: "mother-baby unit", "maternal mental health", "postpartum mental health" and "postnatal psychiatry".
Results: The MBU are considered the best practice by the National Institute for Health and Care Excellence (NICE) and their guidelines for Antenatal and Postnatal Mental Health recommend MBUs be staffed by specialist perinatal mental health staff. The postnatal period is a critical time for mother and baby binding and there is scientific evidence that separating the mother and infant during the first year could impact negatively on the developing attachment relationship and be a detrimental and traumatic experience for both. Also, by committing both mother and baby, we have an opportunity to watch and guide the mother to baby care. The United Kingdom pioneered in MBUs and in 1958 opened the first separate MBU and then France opened theirs in 1979 and Belgium in 1990.
Conclusions: To summarize, the dyad admission, allows for the mother to receive adequate treatment for her psychiatric disorder, whilst also receiving support in developing parenting skills. In the last years many countries worldwide have adopted this as standard of care, with excellent outcomes for both mother and baby.

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Psychological adjustment to infertility and its effect on mental health in women

M. Mitrović[1], N. Ćirović[1]*, J. Opsenica Kostić[1], I. Janković[1], M. Guberinić[1], M. Spasić Šnele[1] and M. Trenkić[2]

[1]Department of Psychology, Faculty of Philosophy, University of Niš and [2]Faculty of Medicine, University of Niš, Niš, Serbia
*Corresponding author.
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Introduction: Infertility represents a serious biopsychosocial crisis. Faced with infertility in a society that emphasizes parenthood as a desirable role, and driven by their own desire to become a parent, a person is forced to (re)define themselves as an adult and find their place in society. Research shows that women are more affected by this issue. Firstly, medical treatment for infertility is more uncomfortable for women than for men. Moreover, in most societies, women are considered the responsible partner for reproduction. The experience with this problem can be traumatic enough to become a reference point for identity and for attributing meaning to other experiences in one’s life.
Objectives: This research aimed to examine the mediating role of psychological problems caused by infertility in the relationship between self-stigma and the degree of integrating trauma (i.e. infertility) into one’s identity, on the one hand, and the level of depression, on the other.
Methods: The study involved 197 women with difficulties conceiving who had not yet become mothers, aged between 27 and 47 years (M=37.7; SD=5.1). The following questionnaires were used: the Female Infertility Stigma Instrument (ISI-F), designed to assess self-stigma in women facing infertility. The Centrality of Event Scale (CES) measures integrating trauma into one's identity (adapted here to measure the integration of infertility into one's identity). The Psychological Evaluation Test for Infertile Couples (PET), is aimed at assessing psychological problems in various aspects of life caused by infertility, and the Patient Health Questionnaire (PHQ-9), is used to assess the degree of depression.
Results: The results show that the zero-order correlations between the predictors, mediators, and criterion are positive and significant. Mediation analysis shows that problems caused by infertility mediate the relationship between self-stigma and the level of depression (indirect effect: ß=.292, p< .001, 95%CI = .199 - .411), and between the integration of trauma (i.e., infertility) into one's identity and the level of depression (indirect effect: ß=.147, p<.001, 95%CI = .083 - .226). In both cases, full mediation is observed. Tables and figures will be added to the poster if accepted.
Conclusions: The results indicate that the degree of internalized stigma and the integration of infertility into one's identity are significant for a person's adjustment to this problem and that, together with the level of psychological problems caused by infertility, have an effect on mental health. The study underscores the "traumatic" potential of infertility and the effect of this issue on identity and mental health. The findings could also serve as guidelines for designing psychological interventions, which should focus on the problem of self-labeling, self-blame, and the redefinition of oneself as an adult.

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Mind the gap: gender differences in Attention Deficit and Hyperactivity Disorder

F. Ramalheira[1]*, F. Gonçalves[1], S. Vieira[1], R. Cohen[1], M. Cameira[1] and P. Robalo[1]

[1]Hospital Júlio de Matos, ULS São José, Lisbon, Portugal
*Corresponding author.
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Introduction: Attention Deficit and Hyperactivity Disorder (ADHD) affects both males and females, however, sex differences can be found in presentation, epidemiology and even influence clinical management. Male-to-female ratio is different in childhood from adulthood, meaning girls with ADHD are probably less referred to medical care and underdiagnosed. Women with ADHD have more prevalence of depression and anxiety than men. Also, fluctuating levels of estrogen and progesterone interferes in symptoms and medication response
Objectives: To study sex differences regarding sociodemographic, mental health care access, and psychiatric comorbidity in a sample of patients from our ADHD outpatient clinic
Methods: We collected data from all patients who attended the Adult ADHD Outpatient Clinic of our hospital from 2017-2022 (N = 262), excluding those without written information or an ICD-11 diagnosis of 6A05 - attention deficit hyperactivity disorder (n=209). We performed a descriptive statistical analysis comparing male (n=132) and female (n=76) on sociodemographic factors, educational achievement, age of diagnosis, treatment and comorbidities
Results: Average of age was 39,4 for females (F) and 34,3 for males(M). Levels of primary education were 5% for both, secondary education 41% F and 53% M, and tertiary education 41% F vs 37% M. 30% F and 37% M had failed at least once during their academic path. 26% F vs 25% M were students, 45% F vs 48% M were working actively and 8% F vs 15% M were unemployed. Only 8% F had an ADHD diagnosis during childhood and adolescence whether 41% of M had a history of early diagnosis and/or treatment. At least once psychiatric comorbidity was found in 75% F and 67% M, and medical comorbidities were present in 36%F and 44% M. Comorbid psychiatric diagnosis were anxiety disorders (36% F vs 26% M), depressive disorders (29% F vs 18% M), intellectual developmental disorders (5% F vs 13% M), substance abuse disorders (5% F vs 9% M), bipolar disorder (11% F vs 5% M), and autism spectrum disorders (3% F vs 5% M). In F, 75% were treated with stimulants and 11% with non-stimulants as in M 80% were treated with stimulants and 8% with non-stimulants. 37% F vs 24% M maintain follow-up, while 50% F vs 61% M abandoned it
Conclusions: In our study, women were less diagnosed in childhood and adolescence than men, regardless of failing in school in a similar percentage, which reflects underdiagnose in girls. Women had more percentage of psychiatric comorbidities, including anxiety, depressive, and bipolar disorders, whereas men had more prevalence of substance abuse and intellectual developmental disorders, meaning that women with ADHD are more prone to develop mood-related comorbidities than men. The percentage of follow-up abandon is also lower on women which indicates that, in spite of being less referred to medical care for ADHD, they are probably more likely to adhere to treatment

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The association between childhood trauma and facial emotion recognition in women with premenstrual dysphoric disorder

A. Vardiampasis[1]* and C. Gramandani[1]

[1]Mental Health Center, General Hospital of Rethymno, Crete, Rethymno, Greece
*Corresponding author.
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Introduction: Facial emotion recognition is a fundamental component in social interaction. Facial emotion recognition is disturbed both in women with Premenstrual Dysphoric Disorder (PMDD), and in those with a history of childhood trauma. PMDD affects up to 5% of women of childbearing age, exert influence on women's recognition of emotions, and on the emotion recognition processing. Women with PMDD are more likely to have a history of childhood trauma.
Objectives: To explore whether there is a link between a history of trauma and the perception of emotions in women with PMDD. We hypothesize that women with PMDD and a history of childhood trauma will show larger deficits in emotion recognition compared to women with PMDD but without a history of childhood trauma.
Methods: Data were derived from a sample of forty women diagnosed with PMDD (18-30 y.o., right handed, educational level >9y., regular cycle duration), who have visited Mental Health Centre of Rethymno (participants completed the Premenstrual Syndrome Questionnaire). The participants completed the Childhood Trauma Questionnaire (CTQ), which measures five types of maltreatment experiences. Three types are related to abuse (physical, sexual and emotional) and two to physical and emotional neglect. The Emotion Recognition Task (ERT) was also administered. ERT is a computer-generated paradigm for measuring the recognition of six basic facial emotional expressions: anger, disgust, fear, happiness, sadness, and surprise. During this test, video clips of increasing length are presented.
Results: The majority of the participants (82.5%) reported a history of maltreatment during childhood. Women without trauma, when they completed the ERT did not show any significant emotion dysregulation. On the contrary, maltreated women, especially physically or sexually abused, had a distorted perception of emotions expressed on adult faces. Happiness is less detected, whereas fear and anger are recognized more rapidly and at a lower intensity compared to women not exposed to childhood trauma. The higher the score in abuse, the higher the emotion dysregulation is.
Conclusions: The main conclusion of this study contributes to the current knowledge on the link between the long-term effects of childhood trauma both to PMDD and to emotion dysregulation. Women with PMDD are more likely to have a history of childhood trauma, which is associated with poorer performance in facial emotion recognition. Trauma, however, is a treatable factor with. Therefore, interventions targeting both to heal trauma and to promote adaptive emotion regulation strategies, could be encouraged to improve the capability of women with a history of childhood trauma to challenge premenstrual symptoms.