Objectives: The objective of the study was to determine the relationship between depressiveness and the occurrence of eating disorders, i.e., emotional eating, uncontrolled eating, cognitive restraint of eating, and the risk of orthorexia.
Methods: The study was conducted among 556 women from the West Pomeranian Voivodeship (Poland). The study employed the diagnostic survey method using a questionnaire technique: The Beck Depression Inventory, the ORTO—15 Questionnaire, the Three-Factor Eating Questionnaire, and a sociodemographic questionnaire.
Results: Higher depressiveness severity is associated with a higher score on the "Cognitive Restraint of Eating" scale. The authors' original study demonstrated a statistically significant relationship only between depressiveness and the "Uncontrolled Eating" subscale ($p = 0.001$).
Table 1. A multivariate model without moderation—analysis of the effect of sociodemographic variables and the severity of depressiveness according to the BDI on cognitive restraint of eating according to TFEQ-13

	Level	ß	−95% CI	+95% CI	t	p
Marital status	Single (ref.)					
	In a relationship	0.091	0.005	0.176	2.084	0.038
Professional activity	Inactive (ref.)					
	Active	−0.046	−0.135	0.043	−1.008	0.314
Age		−0.166	−0.260	−0.073	−3.511	<0.001
BDI (scoring)		0.228	0.147	0.309	5.527	<0.001

ref.—reference level, ß—standardized regression coefficient, CI—confidence interval, and BDI—Beck Depression Inventory
Table 2. A multivariate model with moderation—analysis of the effect of sociodemographic variables and the severity of depressiveness according to the BDI on cognitive restraint of eating according to TFEQ-13

	ß	−95% CI	+95% CI	t	p
Absolute term				1.914	0.056
Marital status*BDI	0.015	−0.147	0.176	0.178	0.859
Age*BDI	−1.344	−6.233	3.545	−0.540	0.589
Professional activity*BDI	−0.037	−0.236	0.162	−0.362	0.717
Educational background*BDI	0.013	−0.145	0.171	0.165	0.869
Residence *BDI	0.153	0.002	0.305	1.994	0.047

ref.—reference level, ß—standardized regression coefficient, CI—confidence interval, BDI—Beck Depression Inventory, and * moderation effect
Conclusions: The results of this study suggest that depressiveness is an important factor that contributes to a better understanding of eating behaviors. In addition, the results of this study suggest that eating behaviors and psychological factors should be taken into account in psychological interventions in the treatment of eating disorders. The clinical goal can be considered to be an improvement in non-normative eating behaviors, such as a reduction in overeating episodes or eating less frequently in the absence of a feeling of hunger.

Disclosure of Interest: None Declared

EPV0719

Deontological guilt feelings in eating disorders: data from an Italian experience

F. Raffone[1]*, D. Atripaldi[2], F. Mancini[3], A. M. Saliani[3] and A. M. Monteleone[4]
[1]Department of Mental Health, Asl Napoli 1 Centro,Università degli Studi della Campania "L. Vanvitelli"; [2]Department of Advanced Medical and Surgical Sciences, Università degli Studi della Campania "L. Vanvitelli", Naples; [3]Scuole di Psicoterapia Cognitiva APC-AIPC-SPC-SICC, Rome and [4]Department of Mental Health, Università degli Studi della Campania "L. Vanvitelli", Naples, Italy
*Corresponding author.
doi: 10.1192/j.eurpsy.2025.1406

Introduction: Guilt and shame are common emotional experiences that may influence the prognosis and treatment of many psychiatric disorders.
Objectives: The aim of this study was to examine the role of guilt and shame in individuals with eating disorders (ED).
Methods: Forty-three adults diagnosed with anorexia nervosa, bulimia nervosa, and binge eating disorder were included in the study. They completed the following questionnaires: the Moral Orientation Guilt Scale (MOGS), which measures different components of guilt, and the Eating Disorder Inventory 2 (EDI-2), which measures ED psychopathology. To assess the relationships between MOGS and EDI-2 subscales, Spearman's correlations and a stepwise multiple regression have been conducted including all patients in a unique ED group.
Results: Positive correlations were found between the EDI-2 bulimia subscale and the MNV (moral normal violation) subscale of the MOGS (0.26, p.=0.05), between the EDI-2 interpersonal distrust subscale and the MNV subscale of the MOGS (Rho=0.28, p=0.03), and between the EDI-2 interpersonal distrust subscale and both altruistic guilt components of the MOGS (Rho=0.33, p=0.01 for harm; Rho=0.29, p=0.03 for empathy). The multiple linear regression model was significant (R^2=0.29, F=8.38, p.<0.01) and showed age (t=-2.9, p<0.01) and the HARM subscale (t=3.4, p<0.01) as predictors of interpersonal distrust.
Conclusions: The results provide preliminary evidence for a possible role of guilt in the aetiopathogenesis of ED. Sensitivity to altruistic guilt, and especially to the harm caused, seems to influence the ability to trust others. Avoidance, distancing, or closure may be strategies to overcome high sensitivity to guilt. Further studies with larger samples, including both ED patients and healthy individuals, are needed to determine the role of guilt in EDs.

Disclosure of Interest: None Declared