and enhance the smartphone-based solution in order to improve engagement. Consensus on how to report UEIs and validate digital solutions, especially for chatbots, are required.

Disclosure of Interest: None Declared

O0098

Virtual self-conversation to support people living with obesity when starting their change process towards a healthier lifestyle: Preliminary results of a longitudinal study

P. Lusilla[1]*, D. Anastasiadou[2], P. Herrero[2], J. Vazquez[2], B. Spanlang[3], M. Slater[3], J. A. Ramos[1], G. Parramon[1], A. Ciudin[4] and M. Comas[5]

[1]Psychiatry, Huvh; [2]Psychiatry, Vhir; [3]Virtual BodyWorks; [4]Endocrinology and [5]Obesity Unit, Huvh, Barcelona, Spain
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.302

Introduction: People living with obesity (PLWO) often experience ambivalence when starting their change process towards a healthier lifestyle. Psychological treatments for obesity should resolve this ambivalence and help PLWO to explore their own reasons for change in line with their needs and values, as well as promote self-efficacy. Following the Motivational Interviewing (MI) principles, the SOCRATES project proposes a "virtual self-conversation" to help PLWO to address some of the psychological aspects associated with obesity, such as the lack of awareness about their condition, the impact of the internalization of weight stigma, and the lack of self-efficacy.
Objectives: With the current longitudinal study, we aim to explore how the participants' process of lifestyle change, and how their eating habits and dysfunctional eating patterns change before and after the virtual intervention.
Methods: Forty-eight patients with obesity from the Vall d'Hebron University Hospital (Mean age = 19.7 years) were assigned to 3 groups. The Experimental Group 1 (EG1) (N = 21), after completing an intensive training on MI, received a virtual intervention using the "motivational self-conversation" technique. The Experimental Group 2 (EG2) (N = 17) underwent a virtual intervention with a pre-registered psychoeducational dialogue, and the Control Group (CG) (N = 10) followed treatment-as-usual. All participants completed self-reported questionnaires on their motivation to change lifestyle [(*Readiness Rulers (RR), Processes of Change questionnaire in weight management (P-W)*], eating habits (*Habits questionnaire*) and dysfunctional eating patterns (*Three Factor Eating Questionnaire-18*) at baseline (T0), post-intervention (T1), and 4 weeks follow-up (T2). Repeated measures ANOVA was performed for all the questionnaires.
Results: Statistically significant results were shown regarding motivation to change through the RR and the "evaluation of the consequences of their weight" subscale of P-W across time for the EG1 ($p < .05$). These results suggest that participants' motivation to eat healthier and do more exercise, as well as self-awareness about the negative consequences of their condition increased after the virtual intervention.
Conclusions: The present study showed that this novel virtual intervention might be an effective tool in helping PLWO resolve their ambivalence to change lifestyle and acquire self-awareness about their condition. However, the intervention did not lead to significant changes in other psychological variables, such as lifestyle habits or dysfunctional eating patterns; domains that may be less sensitive to changes over the time, and which may take place once motivation is well-established.

Disclosure of Interest: None Declared

O0099

Digital CBT-I versus stepped-care CBT-I to prevent depression one year later

P. Cheng*, D. Kalmbach, C. Sagong, C. Fellman-Couture and C. Drake

Sleep Research, Henry Ford Health, Novi, United States
*Corresponding author.
doi: 10.1192/j.eurpsy.2023.303

Introduction: Insomnia is a robust risk factor for depression. Treating insomnia with digital CBT-I (dCBT-I) has been shown to prevent future episodes of depression; however, remission rate of insomnia following dCBT-I is lower compared to face-to-face CBT-I (fCBT-I), which may reduce the effect on depression prevention. A stepped-care model can optimize care by starting with a least resource intensive intervention (step 1: dCBT-I) and stepping-up non-remitters to specialized treatment (step 2: face-to-face CBT-I).
Objectives: This study examined the efficacy of a stepped-care approach to prevent depression.
Methods: 1018 individuals with DSM-5 insomnia and no depression were randomized into two conditions at step 1: dCBT-I (n=613), or an online sleep education control (n=624). Participants in the dCBT-I condition who did not show remission for insomnia (ISI>9) were further randomized to either face-to-face CBT-I (n=103) or sleep education (n=104). Rates of clinically significant depression (moderate severity and above) was assessed at one-year follow-up.
Results: Insomnia remission rates were higher in the dCBT-I group (40%) compared to the control group (22%). Those who did not remit following step-1 dCBT-I showed step-2 insomnia remission rates of 75% following fCBT-I compared to 38% following the step 2 control.
At one year follow-up, the incident rate of clinically significant depression was 2.4 times higher in those who received control (13.2%) compared to fCBT-I (5.5%) at step 2. Depression rate was 10.1% in those who did not receive dCBT-I at step-1.
Conclusions: Preliminary evidence from this study provide supported that a stepped-care approach may produce greater protection against incident depression than dCBT-I alone.

Disclosure of Interest: None Declared