total submission and using him as a patch to her ego. For a long period of the treatment the patient resorted to angry silences or attacked the analyst verbally.

The point we would like to make is that a decisive moment in the substitution of the acting out behaviour by the mentalisation process was when the patient's body came to represent the analytic setting, allowing productive interpretative work in this way around the issue of the body boundaries.

## P36.05

Clinically significant subgroups of borderline personality disorder (PD)

S. Karterud[1]*, G. Pedersen[2]. [1]*Ullevål University Hospital, Psychiatric Division, Oslo;* [2]*The Norwegian Network of Psychotherapeutic Day Hospitals, Norway*

**Objective:** To identify clinically significant subgroups of borderline PD.

**Material:** 356 patients with borderline PD being treated in the Norwegian Network of Psychotherapeutic Day Hospitals.

**Methods:** The diagnostic interviews SCID-II and MINI at admission, and the outcome measures GAF, SCL-90R, IIP and QoL at admission, discharge and follow up.

**Results:** Two major subgroups were identified: One borderline/paranoid subgroup (n=70) and one borderline/cluster C subgroup (n=275). The borderline/cluster C subgroup ("soft" borderline)had a significantly better ($p<.05$) status at all measure points. The difference had increased by follow up.

## P36.06

Personality disorders after traumatic brain injury

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**Objective:** The authors evaluated the occurrence of personality disorders in patients with traumatic brain injury (TBI).

**Method:** Sixty patients were assessed with the Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II) on average 30 years after TBI. Organic personality syndrome was diagnosed on a clinical basis according to DSM-III-R criteria.

**Results:** Fourteen patients (23.3%) had at least one SCID-II personality disorder. Five out of 14 patients (35.7%) had more than one personality disorder. The most prevalent individual disorders were avoidant (N=9; 15.0%), paranoid (N=5; 8.3%), and schizoid (N=4; 6.7%) personality disorders. Nine patients (15.0%) had organic personality syndrome, and five of them (55.6%) had a comorbid SCID-II personality disorder. Thus, personality disorder or organic personality syndrome was observed in 18 individuals (30.0%). The subtypes of organic personality syndrome were: combined N=5 (8.3%; labile + disinhibited N=4 and labile + paranoid N=1), disinhibited N=2 (3.3%), paranoid N=1 (1.7%), and apathetic N=1 (1.7%).

**Conclusions:** TBI may cause personality disturbances in some individuals. These disturbances can impair compliance with rehabilitation. Our findings emphasize the importance of psychiatric evaluation after TBI.

## P36.07

Informant's report of defense mechanisms in depression

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**Objectives:** This study compared the assessment of defense mechanisms by the patient and a close informant in depression. **Methods:** 63 in-patients who met DSM-IV criteria for major depression were administered at beginning and after 4-weeks of treatment, the HDRS and the 40-item Defense Style Questionnaire (DSQ) according to his current state. A close informant completed an adapted version of the DSQ, at DO and D28 according to the subject's current and premorbid states. Agreement between the two methods was measured using intra-classe correlation coefficients and means were compared using paired *t* tests.

**Results:** Overall agreement in the assessment of defense mechanisms was moderate, even if there was no difference between the mean scores. The informant was able to discriminate premorbide and pennorbid states as well as improvement and to assess retrospectively the patient's usual defensive functioning.

**Conclusions:** The ability of informant to give accurate descriptions of patient's usual defensive functioning could help the clinician to understand his premorbid personality and then to adapt the therapeutic strategy.

## P36.08

Self-injurious behavior and skills use: an inpatient DBT treatment for borderline patients (BP)

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**Objectives:** (1) To correlate type and frequency of self-injurious behavior (SIB) and successful use of skills in a 12 week inpatient Dialectic Behavioral Therapy (DBT) treatment program for chronically suicidal and self-mutilating women. (2) To rule out whether the expected decrease of SIB in DBT is caused by additional drug intake or by the usual clinical management.

**Methods:** 21 BP within DBT and 9 matched inpatient BP with clinical management were studied. All Patients had 12 weeks of treatment. We measured type and incidence of SIB, the number of successful skills and medication used. We controlled 9 DBT-patients and 9 patients in the control group in a matched pairs design.

**Result:** There was a significant decrease of SIB and a significant increase in the successful use of skills in DBT. Comparison of the two matched groups showed a significantly higher decrease in DBT. There was no symptom shift and no increased use of drugs during the DBT treatment.

**Conclusions:** The DBT-inpatient treatment proved efficacy in reducing SIB. The results suggest that during an inpatient DBT treatment BP learn to regulate tension by using skills, not by drug. usage or plain clinical management.

## P36.09

Prevalence and clinical characterization of personality disorders in a sample of juvenile offenders

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Our study aimed to estimate the prevalence of personality disorders (PD) in a sample of juvenile offenders detained in the penitentiary

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of Airola (Campania, Italy) and to describe the clinical and psychopathological profile of these subjects.

The subjects were evaluated by the structured diagnostic intervew for the DSM-IV axis II disorders (SCID II), the Minnesota Multiphasic Personality Inventory (MMPI), the State Trait Anger Expression Inventory (STAXI) and the Eysenck Personality Questionnaire (EPQ).

At present our study shows a high frequency of paranoid (46%), narcissistic (35%) and borderline (35%) personality disorders.

The significant social consequences of PD and the need of an effective treatment call for more detailed epidemiological and psychopathological research aimed to develop well-targeted rehabilitation programs.

## P36.10

A study of quality of life in outpatients with personality disorders

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Very few studies have examined the quality of life in personality disordered patients, but indicate reduced levels. Such studies of patients with anxiety disorders and depression have not considered comorbid personality disorders.and compare the measurement of those found in a normal population. In addition, we also wanted to study the influence of comorbid axis I disorders on the QoL in PD, and the change of QoL over a two-years period in PD patients.

130 patients were included and 87 (66.9%) of them had PD as diagnosed by the IPDE, and they constituted the PD group. Sixty one (70.1%) of these patients also had at least one comorbid axis-I disorder as diagnosed by MINI. Forty-three (33.1%) patients had only Axis I-disorders. Among these patients 68 (78.2%) of those with PD delivered complete SF-36 forms at baseline and 36 (83.7%) of those in the axis I-group delivered such forms. Significant lower scores were found in the PD patients compared to the Axis I and control group.

# P37. Philosophy and psychiatry

## P37.01

Neurosciences, memory and self. Introduction to the work of G.M. Edelman

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G.M. Edelman (*1929) was nobel-prize winner in medicine/physiology in the year 1972 (antibody-structure). He first worked as physician in Boston and New York, where he was a Professor at the Rockefeller University since 1966. In 1981 he became Director of The Neurosciences Institute in San Diego, CA. He is founder of The Neurosciences Research Foundation. Together with G. Tononi, G. Reeke, and O. Sporns he developed and presented an empirical neuroevolutionary conception for a dynamic interpretation of brain and mind processes. The 'theory of neuronal group selection' is cornerstone of this concept, which allows to introduce the term 'Memory' and 'Self' into neurosciences within a methodological moderate constructivism. After the fundamental conception of 'The mindful brain' (1978), Edelman presented the monumental trilogy of I. 'Neural darwinism' (1987), II. 'Topobiology' (1988), and III. 'The remembered present' (1989). He added 'Bright air, brilliant fire' (1992). 'A universe of consciousness' (2000) finished the neuroscientific concept. The widespread discussion from neurosciences to psychoanalysis is documented in 'Selectionism and the brain' (1994). The following considerations want to present a reconstruction of the basic lines in the work of G.M. Edelman.

## P37.02

Diagnostic procedure in psychiatry: the structuralist approach

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This paper aims at making explicit the procedure a psychiatrist necessarily performs when taking a diagnostic decision. The ultimate goal of psychiatrist is to build a holistic model of the patient's pathological state, including symptoms of the disease, its dynamics, personality traits, protective mechanisms etc. In the diagnostic decision-making psychiatrists heavily rely on their professional knowledge, clinical experience, intuition etc. However, the components of the diagnostic procedure and their relationships seem to be inadequately explicated.

Three components of such procedure are defined: analysis of the narrative and/or behavior of the patient, approximation to the holistic understanding of the patient's state, i.e. of his/her 'inner world', and determining the conformity of the observed symptoms to the 'inner world'. In a clinical situation, pathology may and may not be found in any of these objects independently. We argue that a wide spectrum of cases under psychiatric diagnosis may be meaningfully described as a combination of (pathological) disturbances in one or more of these objects of analysis. Focusing on psychosis, an attempt is made to build descriptive categorization of psychotic and non-psychotic phenomena on the basis of the diagnostic triad.

## P37.03

Contemporary history of psychiatry

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In this lecture I will describe the development of the last century's Western psychiatry, and attempt to show how cultural and political events together with psychiatric research findings have influenced the medical paradigm.

German psychiatry which until the 1930s had had a domineering worldwide influence, was after the war bankrupt both morally and institutionally, and became more or legs isolated until the end of the 1950s. Thus, after the war Western psychiatry was coloured by American psychoanalysis, British social psychiatry, and from the mid-50s French psychopharmacology.

The 1960s was a time of political unrest and radical social critique with anti-authoritarian trends, which was also reflected in clinical practice. These years were characterised by new stimulating ideas, ,such as existentialism, communication theory and psychoanalysis, as well as a strong belief in the importance of environmental factors. This was also a time for anti-psychiatric critique of the psychiatric professions with its diagnostic culture and large institutions.

During the 1970s the psychiatric beds in the mental hospitals were drastically reduced, particularly in the United States and Great Britain. These years also heralded a culture change in psychiatry that was closely connected with the biological wave, which had influenced the intellectual climate of Western society during the last thirty years. Psychoanalysis declined in popularity, and an increasing interest in classification culminated with the American DSM-III of 1980. The new American diagnostics was rapidly employed internationally and had a revolutionary influence, not only on psychiatric classification, but also on psychiatric thoughts in

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