

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)

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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-class 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 premorbid and pendorbid 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