Results The clinical case involves a 62-year-old man, with no psychiatric history, who begun to present depressive symptoms, emotional lability, aggressiveness and amnesic deficits with 4 months of evolution. After realize an exhaustive clinical evaluation, a cerebral MRI and LCR analysis, the results were consistent with seronegative AI LE. The patient was treated with corticoid therapy and presented a favorable evolution, with remission of the symptoms.

Conclusions Even though it is a rare pathology, AI LE is an important differential diagnosis to consider in patients with psychiatric symptoms and it is essential to enhance the early detection and treatment of this pathology. This condition also reinforces the role of AI diseases in psychiatric disorders in general, an area, which requires further investigation. With this clinical case, we expect medical professionals to be able to recognize the importance of this diagnosis.

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e-Poster Viewing: Psychopathology

EV1045

Behavioral disorders: Within the limits of psychiatry or neurology? About a case

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It has been a clinical case of a polimorphic psychotic disorder in a male of 26-year-old, affected by brain palsy, previously with adequate cognitive function, undergoing remarkable confusional fluctuations and a waking state apparently well-preserved. As possible comorbidities or triggers we could count on a tonsillitis and/or a depressive reaction a few days before. Serious consideration must be given to a differential diagnosis with an encephalitis but, despite the presence of an intermittent febricula, it was rejected by both units: internal medicine and neurology, after performing some complementary tests, albeit some more specific tests are still pending. His psychiatric background was also checked, which initially was orientated as a questionable bipolar disorder. At all events, symptoms stopped progressively until, almost complete remittance in the moment he was discharged from the hospital. He recovered his normal functionality. The treatment given was risperidon 2 mL/day, quetiapin 50 mg/8 h and baclofen 10 mg/12 h. This can be used as an example of how many difficulties we usually found to catalogue an acute disorder in first phases, even to encompass the clinical profile within the limits of psychiatry or neurology.

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EV1046

The role of dissociation in patients with a diagnosis of borderline personality disorder and adverse attachment experiences

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In literature, the link between childhood abuse stories, trauma, unresolved attachment and psychopathological manifestations characterized by the presence of significant dissociative symptoms are well documented. The treatment of this kind of clinical pictures is very problematic because of dysfunctional relational dynamics acted by patients. As we know, borderline personality disorder patients and those with unresolved attachment show poor emotion regulation. About that, a very recent study found an alteration of the neural mechanism involved in the top-down control process of emotional distress both in BPD patients and in those with unresolved attachment. In this context, to make an accurate psychological assessment is essential to define and understand the overall patient functioning and identify the most appropriate therapeutic strategies. In this study, we have selected 22 women characterized by a diagnosis of borderline personality disorder, dissociative experiences and childhood abuse stories. The psycho-diagnostic examination of this sample involved the use of the following tools: Rorschach, MMPI-2, WAIS-R and drawing tests. Consistent with the literature, the outcomes confirmed the presence of response patterns related to trauma, abuse stories and dissociation in both Rorschach and MMPI-2. At the same time, in a significant portion of the sample, we have found an intact cognitive functioning; this aspect, as showed by other authors, highlights the adaptive function of the defensive mechanism of dissociation.

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EV1047

Psychopathology of depersonalization and de-realization. What is the limit between normal and pathological?

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A 21-year-old woman, distance-learning psychologist with a history of parent violence during her early childhood in the context of her father's alcohol poisoning, describes experiences of depersonalization and de-realization, of which she is aware since the age of five years, in situations of stress or out, for example, when looking in the mirror or even playing. She consulted to psychiatry, seven months after his father died of lung cancer, he frequently smoked tobacco and cannabis at home, had been diagnosed a year before his death. The patient described increased anxiety symptoms, with panic attacks, hypnopompic and hypnagogic hallucinations, and increased depersonalization and de-realization phenomena. She denies the use of psychoactive substances in addition to tobacco and alcohol, occasionally. Likewise, the depressive symptomatology was objectified in relation to the grief for the loss of his father. She received treatment with SSRIs and two months later, referred partial remission of symptoms, with persistence of dissociative symptoms. In addition, she presents emotional instability, feelings of emptiness, self-defeating ideas without structured suicide ideation. In recent months, he has presented avoidant behaviors and isolation with affectation in his habitual functioning. Now, in this case: are depersonalization and de-realization normal, part of the anxiety crisis, a sign of a high-risk mental state, or a prelude to a serious mental illness?

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