are no current brief yet comprehensive scales to measure outcome in the elderly. If the HoNOS was proved valid and reliable in the elderly, it would be useful both for longitudinal studies and as a standard measure across differing age groups.

Method One hundred elderly patients, a representative sample from each of the main sources of contact With psychiatry of the elderly i.e residential homes, out-patients, day hospital patients, acute in-patients, liaison geriatric patients and patients on the continuing care wards, were rated using the HoNOS, CAPE-BPRS, SF36, BPRS, QOL, CDR, GAS, MMSE and given a diagnosis using the DSM IV. *Concurrent validity* was tested in comparison with the CAPE-BRS, SF36, QOL, CDR, GAS and the MMSE. *Consensual validity* was ascertained through sending the HoNOS for comment to 30 experienced professionals working with the elderly in the fields of social work, psychiatry of old age, nursing clinical psychology and occupational therapy. *Content validity* was assessed by consulting with 20 carers and with users groups such as the Alzheimer's disease society, Age concern and MIND. *Test-retest reliability* was assessed by one rater repeating the HoNOS measures on 30 day hospital patients after a period of 1 week. *Inter-rater reliability* was assessed by concurrent assessment by 2 raters of 30 day hospital patients. Internal consistency was assessed using Cronbach's alpha.

Results Concurrent validity of the HoNOS was as good or better than the recognised scales ($p < 0.001$). Internal consistency was adequate with Cronbach's alpha = 0.61. Inter rater and intrarater rehabilities were adequate or good for all items, Cohen's Kappa values = 0.56–0.90. Of the 30 comment in assessing consensual validity, 5 considered the HoNOS to be suitable as it was, 8 made a few minor comment, 15 suggested additional items or improved glossary and 2 suggested major modification of the scale. Content and consensual validity suggested that there were a) Omissions of the carer's views, b) The scale assessing cognition may need an improved glossary or modification, c) The scales assessing depression and relationships needed an improved glossary, d) The scales covering daily living skills and lack of services needed modification.

Conclusion The HoNOS could be used in the elderly population in its present form but would be improved with addition of items covering carer's views and basic and complex living skills and the revision of the glossary covering some of the other scales.

CABBAMAZEPINE ADDITION IN ANTIDEPRESSANT-RESISTANT UNIPOLAR ELDERLY DEPRESSED PATIENTS

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Twelve inpatients of both sexes with recurrent Major depression of unipolar type (DSM-III-R), > 60 years, were included in this open trial of a 4-week duration. All patients were partial or non-responders to at least 4 weeks of monotherapy by tricyclic antidepressants. They were added Carbamazepine (mean dose — 400 mg/day). Efficacy of applied therapy was measured using the $HAMD_{17}$. Response to treatment was defined as a 50% drop of greater or ≤ 12 in the $HAMD_{17}$ score and the CGI of either very much improved or moderately improved from the start of Carbamazepine addition.

Six (50%) of 12 patients demonstrated significant improvement ($HAMD_{17}$ score — 20.7 at baseline, 10.8 after 4 weeks of Carbamazepine addition, 53%). There were no significant differences between responders and non responders.

DIAGNOSTIC AGREEMENT BETWEEN THE DSM-IV AND ICD-10-DCR CRITERIA FOR PERSONALITY DISORDERS: A PILOT STUDY COMPARING THE SCREENING INSTRUMENTS

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Objective: Preliminary assessment of diagnostic agreement for personality disorders (PD) between DSM-IV and ICD-10 Diagnostic Criteria for Research (ICD-10-DCR). *Method:* The SCID Personality Screen Questionnaire, modified for DSM-IV and ICD-10-DCR, was administered to 32 consecutive outpatients. *Results:* The number of patients with the SCID-derived diagnoses that DSM-IV and ICD-10-DCR share in common, was as follows: 6 (DSM-IV) and 8 (ICD-10-DCR) for avoidant/anxious PD, 11 in both DSM-IV and ICD-10-DCR for dependent PD, 10 (DSM-IV) and 12 (ICD-10-DCR) for obs.-compulsive/anankastic PD, 5 in both DSM-IV and ICD-10-DCR for histrionic PD, 15 (DSM-IV) and 8 (ICD-10-DCR) for borderline PD, 1 (DSM-IV) and 2 (ICD-10-DCR) for antisocial/dissocial PD, 10 (DSM-IV) and 14 (ICD-10-DCR) for paranoid PD, and 8 (DSM-IV) and 14 (ICD-10-DCR) for schizoid PD. The diagnostic agreement between DSM-IV and ICD-10-DCR, as expressed by the kappa values, ranged from 1.00 for dependent PD and histrionic PD to 0.60 for schizoid PD and 0.54 for borderline PD. *Conclusions:* DSM-IV and ICD-10-DCR show variable agreement regarding diagnoses of PD. The similar and same diagnostic criteria account for the highest agreement for dependent PD and histrionic PD, respectively. A substantial disagreement for schizoid PD may be based on the less specific ICD-10-DCR criteria, resulting in an apparent overdiagnosis of schizoid PD by ICD-10-DCR. In contrast, the ICD-10-DCR criteria for borderline PD are more stringent and result in fewer cases of this PD diagnosed by ICD-10-DCR. However, the heavy emphasis on impulsive behaviour in the ICD-10-DCR criteria for borderline PD may reflect its psychopathology more accurately.

THE OSTEOPENIA OF ANOREXIA NERVOSA: DISSOCIATION OF BONE TURNOVER IN THE DISEASE STATE AND DURING TREATMENT

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Osteopenia is a well recognised medical complication of anorexia nervosa, and is one of the major causes of morbidity in this eating disorder. As the mechanism of this bone loss is unknown there is uncertainty about management. The most likely causes of osteoporosis in anorexia nervosa are the primary nutritional deficiency or the secondary hormonal changes. New markers of bone turnover have been developed which correlate well with the traditional invasive methods. C-terminal type 1 propeptide (PICP), which is formed by cleavage from procollagen, is a measure of bone formation. Urinary pyridinolines like Deoxypyridinoline (DPYR) and serum carboxyterminal crosslinked telopeptide (1CTP), have been used as markers of bone resorption. The aim of this study was to examine bone formation and bone resorbtion markers in a series of patients attending the Eating Disorder Unit, Bethlem Hospital with a diagnosis of anorexia nervosa. In a first crossectional study we examined the difference of these markers between two groups, one of which consisted of 32 untreated patients and a second group of 16 inpatients who had partially gained weight with treatment. Furthermore in a second independent prospective study we examined the change of serum bone markers over a two month treatment period in 20 patients.

In the crossectional study bone resorption was increased in the

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untreated group as evidenced by the raised serum ICTP and urinary pyridinolines. Bone formation was not increased (alkaline phosphatase and serum PICP levels were normal). In the partially treated group, the level of PICP was significantly increased compared to the untreated group (Mann Whitney $z = 2.27$, $p = 0.02$), suggesting that bone formation was occurring. In the prospective study serum bone resorbtion marker ICTP decreased significantly during the two month inpatient treatment ($P < 0.05$) reaching the upper normal range for this marker whilst the serum bone formation marker PICP increased over time reaching statistical significance ($P < 0.01$) within the first month of inpatient treatment. Anorexia nervosa is associated with high levels of bone resorption which is dissociated from bone formation. Weight gain alone reverses this pattern and bone formation increases whilst bone resorption decreases. These preliminary results suggest that the osteoporosis of anorexia nervosa is caused by loss of bone rather than a failure to attain peak bone mass. These findings may have important implications for treatment. Vitamin D and calcium, which stimulate osteoblast activity, may usefully be added as supplements to an improved nutrition program, which is the cornerstone for all treatment of anorexia nervosa.

CONSIDERABLE IMPROVEMENT IN A CASE OF OBSESSIVE-COMPULSIVE DISORDER UNDER TREATMENT WITH CLOZAPINE

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In therapy of obsessive-compulsive disorder (OCD), to date serotonin reuptake inhibitors (SRI) are looked upon as measure of choice together with behavioural therapy. Neuroleptics seem to be favourable only in tic-related OCD, clozapine is reported to deteriorate obsessive-compulsive symptoms in some schizophrenics due to its seroninblocking properties. We report on a 27 year-old woman with OCD and emotionally unstable personality disorder in a chronified course over 15 years who showed a broad spectre of obsessive and compulsive symptoms including compulsive aggressive behaviour (hitting, kissing and embracing other people). She had proven therapy-resistant to clomipramine, paroxetine and several types of psychotherapy including behavioural therapy and family therapy. Haloperidol and cuclopentixol had to be discontinued due to a significant deterioration of compulsive symptoms. Clozapine finally brought a nearly complete remission with respect to aggressive behaviour and amelioration in other obsessive-compulsive symptoms, too. This seems to be the first detailed case report about successful clozapine therapy of OCD. It is contradictory to some theoretical assumptions about the role of serotonine.

SLIGHT MEMORY DISTURBANCES IN THE AGED: WHICH DIAGNOSTIC TOOLS CHOOSE PRIMARY CARE PHYSICIANS?

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We wanted to know, whether primary care physicians use more or less specific diagnostic tools in patients exhibiting beginning memory deficits in old age. We were also interested to get to know whether there is already a "shared" concern depending from specialisation (family physicians (FP) vs. primary care neuropsychiatrists (NP).

We performed a representative survey (145 FPs, 14 NPs; response rate 83.2%) in southern Lower Saxony. Two different written sample case histories were presented to these physicians in a face-to-face interview. Case one described a slight — however progressive for more than 6 months — unspecific memory and concentration problem in an otherwise healthy 70 y old woman, who is free of continuous drug treatments. After asking for diagnostic decisions, we asked for the diagnostic procedures.

The results showed significant differences between the two physician groups with the FPs performing electrocardiography, blood pressure measurements, and routine blood analysis in 62 – 83% (NPs: 14 – 21%). However, 64% of the latter performed a CT or MRI scan (FPs: 13.1%), and 50% of the NPs and only 19.3% of the FPs would applicate neuropsychological tests.

The results show that the special brain diagnostics are considered mainly by the NPs. With reference to the fact that — about 80% of the aged are exclusively treated by their FPs, potential early dementias are not specifically diagnosed.

LIGNES DIRECTRICES POUR L'INTERVENTION DE LIAISON DANS LE STRESS POST-TRAUMATIQUE

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Dans le Stress Post-Traumatique, le traumatisme peut être représenté par un événement qui a représenté une menace sérieuse pour la vie et l'intégrité psycho-physique du sujet, avec issue mortelle pour un ou plusieurs membres de son noyau familial ou relationnel. Il s'agit donc de patients polytraumatisés hospitalisés dans des services non psychiatriques. L'implication du psychiatre est toujours tardive et ambiguë et s'exprime par le contrôle de leur comportement et la communication du deuil.

En réponse, le vécu du psychiatre est dominé par l'angoisse et la colère du fait de:

1) l'envergure du risque somatique ainsi que du risque psychopathologique
2) les temps et les espaces restreints pour l'intervention
3) la lecture de la composante iatrogène
4) la délégation massive

Les lignes directrices de l'intervention de liaison se régulent sur ce qu'il convient de dire et de faire à l'égard du patient et du personnel soignant, ce qui entraîne un taux inévitable de solitude opérationnelle, surtout au niveau du vécu. Notamment: présence du psychiatre en tant qu'interface de communication; communication/travail de deuil; décodification du comportement d'opposition du patient, en tant que vécu de culpabilité et l'avantage éventuel de ce dernier.

THE RELATION OF EATING ATTITUDES TO PSYCHOPATHOLOGY AND PERSONALITY TRAITS IN A SAMPLE OF GREEK HIGH-SCHOOL STUDENTS

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In recent years eating disorders have become the subject of an increasing interest of medical, scientific and lay literature. Concerning etiology it seems that interplay between biological, social and psychological factors is responsible for the origin of these disorders.

The aim of this paper was to investigate the interelations between eating attitudes and psychopathology and personality characteristics in a sample of Greek high-school students.

157 high-school students (97 females and 60 males) were given the following psychometric tests: 1. The Symptom Distress Check List (SCL-90-R), 2. The Eysenck's Personality Questionnaire (EPQ), 3. The Eating Attitude Test (EAT), 4. The Eating Disorders Inventory (EDI), and 5. The Bulimia Investigatory Test, Edinburgh (BITE). Multiple linear regression for the statistical analysis of data was employed.

The results have shown a positive correlation between EDI and al-

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