family life cycle, and of varying composition. The interview has a semistructured format, which allows a flexible use of standard questions, probes and statements about family life. The SCFI focuses on the family, while encouraging family members to interact spontaneously. The interview consists of four phases including topics such as family togetherness, areas of conflict and disagreement, discipline and decision making, and issues of roles and responsibilities.

The family interviews were video-recorded and later used for the rating of EE. This was conducted by following the same rules as for the rating of EE using the CFI (Left and Vaughan, 1985; Vaughan and Left, 1976).

The subjects in this study consisted of 53 families in two main groups: 41 families with an anorexic patient and 12 families with a bulimic patient. Our eventual sample of 79 relatives consisted of 40 mothers, 27 fathers, and 12 husbands. All patients were women and their mean age was 26 years (range = 18–45 years).

The results indicate that the levels of Critical Comments (CC), Hostility (HOS), Emotional Over-Involvement (EOI) and Positive Remarks (PR) were rated low (e.g. 16 families (30%) made no CC and 17 families (26%) made only one CC). The relatives were rated as being moderately warm in the way they related to the patient during the interview. A comparison between mothers and fathers showed mothers to be significantly more over involved than fathers ($t = -3.68$, $df = 25$, $p < 0.001$). Mothers also scored significantly higher on PR ($t = -2.78$, $df = 25$, $p < 0.01$) and Warmth ($t = -2.56$, $df = 25$, $p < 0.01$) than did fathers. There was no significant difference among relatives in their level of CC and also between anorexics and bulimics in their level of EE index. The clinical and research implications for these findings are discussed.

THE SELF AND OTHER-BLAME SCALES (SOBS)

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This study describes the development and the evaluation of reliability of a new method for the assessment of self/other-blame. The SOBS is an observer-based rating instrument designed to assess self and other-blaming attributions and guilt feelings experienced by patients and their families.

The rating of Self/Other-Blame is decided on the basis of the SOBS segment of the initial family interview. Self/Other-Blame is measured on a 6-point scale from 0 to 5 (0 = none; 1 = little; 2 = some; 3 = moderate; 4 = high; 5 = marked).

The subjects in this study consisted of 36 families in two main groups: 31 (86%) families with an anorexic patient and 5 (13.9%) families with a bulimic patient. Our eventual sample of 91 relatives consisted of 36 patients, 27 mothers, 19 fathers, and 9 husband. Of the 36 patients, 34 were women and 2 were men. The mean age was 26 (range = 18–43).

All families were interviewed using the Standardized Clinical Family Interview (SCFI; Kinston and Loader, 1984). The SCFI is designed to be used with a wide range of labelled and non labelled families, in different stages of the family life cycle, and of varying composition. The interview has a semistructured format, which allows a flexible use of standard questions, probs and statements about family life. The SCFI consists of four phases including topics such as family togetherness, areas of conflict and disagreement, discipline and decision making, and issues of roles and responsibilities. Self/Other-Blame is rated from a segment of the interview in which the family beliefs about the origin of the illness and feelings of guilt-blame are explored. The family interviews were video-recorded and later used for the rating of SOBS. Two independent raters conducted the rating by following the SOBS scoring instructions. Interrater reliability was initially determined by comparing their blind ratings of a sample of 36 interviews.

The results suggest that the Interrater reliabilities calculated by Intra-Class Correlation (CCI) for all SOBS components are high or extremely high (0.80–0.98). A comparison between mothers and fathers showed mothers to be significantly more self-blaming than fathers ($t = -3.89$, $df = 18$, $p < 0.001$). We found no other significant differences among relatives in their level of SOBS.

Applications of the instrument are discussed.

A MEASURE OF PATIENT'S RESPONSE STYLE TO THERAPIST AND THERAPY: THE DEVELOPMENT OF THE PATIENT RESPONSE STYLE SCALES (PRSS)

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This study describes the development and the evaluation of reliability of a newly designed Patient Response Style Scale (PRSS). The PRSS is an observer-based rating instrument designed to assess both verbal and nonverbal communicative aspects of the patient's attitudes and behaviours that are expected to facilitate or impede progress in psychotherapy. The PRSS describes the patient's style of involvement in the interaction and predict the ability to participate in a therapeutic interaction. This instrument is designed to be applied to tape recordings of psychotherapy. The PRSS presently is organized in two subsales, Self-Disclosure (SD) and Emotional Engagement (EE), rated on a 6-point scale.

Patients were 30 consecutive female referrals to the Maudsley Hospital Eating Disorder Clinic, referred for eating disorders who met DSM-III-R and ICD-10 criteria for anorexia nervosa (AN) and bulimia nervosa (BN) and were at or over the age of 18 years. The sample had a mean age of 27 years (range = 18–45). All subjects were interviewed using a clinical/research interview designed for patients suffering from eating disorders. During the interview the patient's eating disorder symptomatology, body weight, menstrual pattern, psychosexual and social functioning, at the interview and during the previous six months, were assessed. The interviews were video-recorded and later used for the rating of PRSS by following the PRSS scoring instructions. This was conducted by two independent raters. Interrater reliability was initially determined by comparing their blind ratings of a random of 30 interviews. The results indicate that the Intra-Class Correlation between two subsales are extremely high (0.92 & 0.94). Three different patient response style (PRS) were designated: dual low PRS, in which neither SD nor EE was high; mixed PRS, in which one PRSS (SD or EE) was rated high and the other was low; and dual high PRS, in which both SD and EE were designated as high. Eight patients were classified as dual low PRS, 3 patients as mixed PRS, and 19 patients as dual high PRS. Of these 3 mixed PRS, 2 patients were rated as high-SD, the other one were high-EE. Further results and discussion will be available when the follow-up study is completed. Applications of the instrument are discussed.

WAR INDUCED POSTTRAUMATIC STRESS DISORDER IN OUT PATIENT PSYCHIATRIC TREATMENT

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The aim of this study was to determine how many patients diagnosed as PTSD sent to undergo the psychiatric examination and therapy really suffer of that disorder and how many suffer from the combination of that disorder combined with other psychiatric disorders, especially alcoholism, or other disorders without PTSD.

We have done the outpatient psychiatric treatment on a sample of

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244 patients from the war-affected areas of the Republic of Croatia. The subjects were exposed to war stress during the second half of 1991 and the first half of 1992. All subjects have been sent as PTSD and the final diagnoses were established according to DSM-IV-criteria and using the structured clinical interview for the evaluation of PTSD. We have examined a total of 244 refugees, 18 (7.40%) females and 226 (92.6%) males. All subjects were between 20–60 yrs of age. Most subjects belonged to the younger age groups 20–40 yrs of age. PTSD alone was diagnosed in 123 (51%), PTSD and alcoholism in 14 (5.70%), PTSD and alcohol abuse in 10 (4.10%), alcoholism alone in 59 (23.70%), alcohol abuse alone in 14 (5.70%), combined addiction to alcohol and anxiolytics in 2 (0.80%), exhaustion of the adaptive capabilities in 10 (5.10%) and the chronic psychoorganic syndrome in 2 (0.80%) of subjects.

COMPARATIVE ROC-ANALYSIS OF THE SIDAM, THE MMSE AND THE ADAS

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Differentiation of dementia and depression in clinical routine requires standardized instruments with high sensitivity and specifity that can be applied in an reasonable amount of time. Short assessment scales might have a lower diagnostic accuracy, whereas more comprehensive instruments might have higher sensitivity and specifity, but are more time consuming.

The aim of the present study was to compare the diagnostic accuracy of instruments with different length by ROC-analysis.

The Mini Mental State Examination (MMSE, Folstein et al. 1975) is a short scale that can be completed in a few minutes. The Structured Interview for the diagnosis of dementia of the Alzheimer type, Multi-infarct dementia and dementias of other etiology according to ICD-10 and DSM-III-R (SIDAM, Zaudig et al. 1990) can be applied in about 25 minutes, while the Alzheimer's disease assessment scale (ADAS, Rosen et al. 1984) needs more that an hour. These scales were administered to 144 inpatients of a university psychiatric clinic (71 with dementia of the Alzheimer type, 73 with major depression). Diagnostic accuracy of the scores, i.e. sensitivity and specifity over the whole range of possible cutoff-points, was measured by the area under the ROC-curve.

Although the MMSE is much shorter, diagnostic accuracy of the SIDAM and the MMSE were equivalent. Both tests performed better than the ADAS in differentiating dementia from depression. Further analysis of the SIDAM revealed, that the SIDAM sum score, covering a whole range of cognitive tasks, better distinguished depression from dementia than any subscore of a single cognitive area, like memory or orientation.

Further assessment should examine, whether comprehensive instruments are preferable to short scales in the staging of dementia.

HOW DOES A TEACHING PROGRAMME ALTER GENERAL PRACTITIONERS VIEWS AND KNOWLEDGE ABOUT DEPRESSION IN THE ELDERLY

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General Practitioners have a central role to play in the management of depression in their older patients. However studies suggest that they tend to underdiagnose and undermanage depression in this age group. Continuing Medical Education is an important part of helping GPs keep up to date and improving their practice. This study evaluated the effect of a short postgraduate training course on the management of depression in the elderly. GPs from two catchment areas attended the courses and their views and knowledge about depression in the elderly were evaluated one month before and six weeks after the course. Following the course there were significant improvements in the GPs' knowledge about antidepressant and psychological treatments. This study highlights some of the problems of "evidence based teaching" but also suggests that old age psychiatrists have an important role to play in the education of their GP colleagues.

THE APPLICATION OF THE EXISTING ETIOPATHOLOGICAL CONCEPTS ON AN OCD CASE

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The integral etiological OCD concept, about which Freud was informing, includes ethological factors, and the of constitutional predisposition, the interaction of instincts with early life experiences (traumas, fantasies late specific defences and object relations), environmental triggers. Neurochemical and neuroanatomical researches, as well as detailed questioning of the family of this patient have given a current contribution to this concept.

This model is illustrated on the patient of the OCD chronical course (the ritual of washing), whose therapy is on. Diagnostics is established with a psychiatric and psychological examination, by the use of the YBOCS and MOCI, as well as neurophysiological research.

It is concluded that, although the psychodynamic model is the most acceptable explanation of the phenomena of this disorder, the response to the cognitive-behavioral therapy and pharmacotherapy is in favour with the neurobiological model.

CLINICAL DIAGNOSIS AND STANDARDIZED EVALUATION OF BORDERLINE PERSONALITY WITH ICD 10: A COMPARATIVE STUDY

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A sample of 69 patients considered by French clinicians as suffering from a borderline personality disorder was evaluated with ICD 10, using the International Personality Disorder Examination.

First, global descriptive analysis elicited the main socio-demographic and clinical characteristics of the sample.

After diagnostic evaluation, the standardized diagnosis matched with the clinical one, for one patient out of two ($n1 = 34$).

The results of the evaluation of the 34 patients diagnosed as borderline both by clinicians and ICD 10 were compared to those of the rest of the sample ($n2 = 35$).

The setting up of dimensional mean profils with IPDE enabled to describe some significant differences between the two sub-groups, especially in terms of height of profils and Borderline personality co-diagnoses. In particular, dimensional scores of Dependent, Histrionic, Dyssocial and Impulsive personality disorder co-diagnoses seem to be significantly different between the two sub-groups.

ATTEMPTED SUICIDE IN CHINESE ELDERLY

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Little known about suicide or attempted suicide in Chinese elderly. Fifty-five patients aged 65 and over referred to the Psychiatric Unit of Prince of Wales Hospital for attempted suicide between July 1990 and December 1992 were studied. The author reviewed the information in the datasheet and the case notes of the study subjects and recorded the demographic data, the psychiatric diagnoses, the past psychiatric and medical history and the details of the suicidal attempt. The rate