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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