MINI-BASDEC: A SIMPLE SCREENING TEST FOR DEPRESSION IN THE ELDERLY

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Introduction: The Brief Assessment Schedule for Depression Cards (BASDEC) is an easily-administered 19-question screening test validated in the elderly (Adshead et al. Br Med J 1992;305:297).

Our study evaluated responses to individual questions in 3 elderly populations, and examined the validity of a shortened BASDEC (mini-BASDEC) as a simpler screening instrument.

Methods: 55 elderly in acute medical wards, 105 out-patients and 230 in Residential Homes were screened using BASDEC for likely depression. 6 questions providing the best compromise between positive and negative predictive values, and 2 further questions -'I've given up hope,' and 'I've seriously considered suicide' indicating severe depression were selected. This mini-BASDEC was tested in 96 outpatients, those screening positive (> 2/8) underwent a semi-structured Psychiatric interview incorporating the Hamilton Scale for Depression and Montgomery-Aspberg Depression Rating Scale. 53 subjects also underwent the New York Task Force (NYTF) single question 'Do you often feel sad or depressed? (Mahoney et al. of Amer Geriatr Soc 1994;42:1006–8).

Results: 96 outpatients (25M: 71F, mean age 80.4 years) were screened using mini-BASDEC, 12/96 (12.5%) scored > 2/8. Of these 6/12 were deemed moderately–severely depressed by a Psychiatrist, (4 with DSM IV criteria of major depression), 2 mildly and 4 non-depressed. NYTF single question was positive in 12/53 (22.6%) but only 3 found as depressed by a Psychiatrist.

Conclusions: Mini-BASDEC seems a simple, reliable screening instrument for depression in different elderly populations. The NYTF single question is relatively non-specific.

Supported by E Merk Pharmaceuticals.

ANXIETY, HYPOCHONDRIACAL BELIEFS AND ATTRIBUTIONS ABOUT COMMON BODILY SENSATIONS

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Background and Objectives: In an earlier study (Sensky, MacLeod & Rigby, 1996) we examined causal attributions about common bodily sensations made by two groups of general practice attenders — one group included people who themselves initiated visits to their doctor frequently (average 12 times annually), while the other comprised infrequent attenders. Somatic causal attributions were equally frequent in each group, but those in the frequent attenders group were much less likely to offer 'normalizing' explanations for bodily sensations eg *I feel hot because the central heating is turned up*. Although matched for age and gender, the groups differed in that the frequent attenders rated as significantly more anxious, and were also more likely to have hypochondriacal beliefs. The present study was undertaken to clarify whether people who are both hypochondriacal and anxious differ from those who are anxious but not hypochondriacal in the attributions of common bodily symptoms.

Methods: Of 95 patients attending two general practices screened, 31 scored as axious and were recruited into the study. These 31 participants were sub-divided on the basis of their hypochondriacal beliefs into anxious hypochondriacal (HA) and anxious control (CA) subjects. All subjects were presented with 10 common bodily sensations, such as *you feel your heart pounding* taken from the Symptom Interpretation Questionnaire (Robbins & Kirmayer, 1991) and given one minute to write down as many reasons as they could why each one might happen to them. Reasons were categorized as somatic, psychological, or normalizing.

Results: The HA group differed from the CA group in generating more somatic reasons and providing a somatic reason more often as their first response. This difference between the groups was not accountable for in terms of differing levels of general anxiety or frequency of past experience of the sensations. In contrast to the results of the earlier study, no differences were found between the groups in the frequency of normalizing attributions.

Conclusions: Anxious individuals with hypochondriacal beliefs have more accessible illness attributions to account for a range of bodily sensations. This may play an important role in the perpetuation of their beliefs, and suggests specific techniques which might be helpful in a brief focal psychological intervention.

MARITAL STRESS IN MENTAL HEALTH IMPAIRMENT: FAMILY STUDY

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Considering the negative impact of distorted interpersonal relations for mental health the pilot study of newly referred within 1 year to psychiatric day-care unit detected essentiality of marital problems for the origin of mental or behavioural disorders in about 60% of cases. The main goal of further family aimed investigation was to reveal and assess the peculiarities of mental disorders and social disfunctioning in adult group (AG) and nongroun-up group (NGG) of family members under marital stress. 60 families (112 adults, 78 children and adolescents) were included into the study applied a number of stress-reactivity and stress-coping assessment instruments as well as life events scoring and clinical scales. Marital stressors were determined either as provoking, pathoplastic or pathogenic factors or as a blend of them in family mental health deterioration. High rates stress related mental disorders with anxiety, depression and aggression overlapping were shown in AG. The most significant mental health corruption was detected in female members of families prominently vulnerable for marital stressors regarding their predominant involvement into family relationships. The evidence of marital stress malignant influence reinforcement by some types of preceding life events was disclosed. The insufficiency of stress-coping strategies was suggested in cases with provoking and pathogenic role of marital stress for emergence and maintenance of mental disorders. NGG was characterized by onset of emotional and conduct disorders under conditions of persistent parents' conflicts. The obtained results established background for therapy framework.

ASSESSMENT OF THE VALIDITY AND RELIABILITY OF THE HEALTH OF THE NATION OUTCOME SCALES IN THE ELDERLY

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Introduction The Health of the Nation Outcome Scales (HoNOS)have been developed to assess changes in the health of patients with mental health problems. The HoNOS was commissioned by the Department of Health to provide a brief standardized assessment procedure to measure outcomes in mental health care settings. The scales are now prepared for use in general adult psychiatry (version 4). However there is no version for use specifically in the elderly, where different difficulties emerge with the increasing prevalence of dementia. There

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

https://doi.org/10.1016/0924-9338(96)89214-5 Published online by Cambridge University Press