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

Ž. Stanković, N. Ilanković. *Institute for Psychiatry, Pasterova 2, 11000 Belgrade, Yugoslavia*

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

V. Starcevic, G. Bogojevic, K. Kelin. *Institute of Mental Health, Belgrade University Faculty of Medicine, Palmotićeva 37, Belgrade, Yugoslavia*

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

N. Stefanis, J. Treasure, H. Abraha [1], C. Moniz [1]. *Institute of Psychiatry, De Crespigny Park, Denmark Hill London SE5 8AF, UK; [1] Department of Chemical Pathology King's College Hospital, London SE5 9PJ, UK*

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)89216-9 Published online by Cambridge University Press