

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.

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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 anxious 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 nongroup-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