the differences of personality traits between Japanese unipolar and bipolar depressive patients by the Japanese Version of Munich Personality Test (JMPT).

Subjects and Methods: 24 recovered DSM-‡V-R major depressives and DSM-‡V-R 13 recovered bipolars were compared with respect to scale values of JMPT.

Results: Both groups, displaying elevated scores on the MPT scales on Extraversion, Rigidity, Neuroticism, did not differ significantly on any of the JMPT scales.

Conclusion: Bipolars as well as unipolars have the component for premorbid personality of the Typus Melancholicus. Regarding premorbid personality, there seems to be no definite difference between unipolars and bipolars. This finding supports the results of the study by Hirschfeld RMA et al. (1986) which revealed the similarity between the recovered bipolar and unipolar patients in regard to personality traits.

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A COMPARISON OF DIAGNOSES ACCORDING TOGMS-A/AGECAT, DSM-III-R AND CLINICIAN'S DEFINITION

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Background: The question 'What is a case?' was raised by psychiatric epidemiologists, especially for geriatric psychiatry, since prevalence rates for diagnoses differ markedly depending on the instrument used. It is mostly not known, which factors contribute to these differences.

Methods: Participants of the Berlin Aging Study (BASE), an epidemiological study of n = 516 persons, aged 70–103 years, underwent standardized psychiatric and geriatric examination. We analyzed diagnostic agreement for dementia (GMS-A/AGECAT vs DSM-III-R) and depression (GMS-A/AGECAT vs DSM-III-R vs clinician's definition [loss of energy and or/interest and at least two further depressive symptoms present for at least four weeks]).

Results: For depression, clinician's definition yielded the highest prevalence (25.8%), followed by GMS-A/AGECAT-diagnosis (19.0%) and DSM-III-R (9.3%), while for dementia the reverse was true (13.8% vs 21.1%). Overall agreement between DSM-III-R and GMS-A/AGECAT was moderate ($\kappa = .71$ for dementia, $\kappa = .48$ for depression), nevertheless adapting thresholds for AGECAT resulted in slightly better diagnostic efficiency. Proportional odds logistic regression, controlling for age; gender; education; MMSE; CES-D; auditory impairment; independent or institutionalised accomodation; BMI; and number of somatic diagnoses showed, that disagreement for dementia was predicted by MMSE-score ($p < .0001$) and living accomodation ($p = .038$), while for depression severity of depression ($p < .0001$), number of somatic diseases ($p = .008$) and auditory impairment ($p = .011$) accounted for disagreement.

Conclusions: Besides conceptual differences and somatic and living conditions, disagreement is mainly caused by different thresholds of diagnostic algorithms. Adaptation of threshold levels should be considered, depending on the purpose of the analysis.

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THE SEVERITY AND PATTERNS OF USE OF PSYCHOTROPICS DRUGS IN NON-FATAL SELFPOISONING

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Background: Overdosing is a widespread form of deliberate selfharm. Psychotropic medications account for 80% of all drug overdoses. The toxicity of drug is major factor for outcome in overdose. The drug overdose accounts for 20% of all suicide deaths.

Design: A retrospective dataset of the 449 consecutive inpatients admitted in Clinic for toxicology for treatment of selfpoisoning during the period January to April 1997 were checked from medical records. The patients were aged from 14 to 77. The severity of intoxication was assesed by clinical parameters: Disturbance of Consciousness and cardiorespiratory functions.

Results: The majority of the drugs were psychotropic in 69%. Benzodiazepines were used most frequently (5.33%), antidepressants (4%), barbiturates (3%), non-barbiturate antiepileptics (1.66%) and antiparcisonics (1.33%) of all selfpoisoning. Opiates were presented in 7.3% cases, Alcohol taken as concomitant substance with Benzodiazepines (10%). Other drugs corrosive agents and pesticides were detected in 13.66%.

Conclusions: Psychopharmaces were the most frequently used drugs in non-fatal selfpoisoning. Benzodiazepines were the most prevalent psychotropic drugs in selfpoisoning and, in common cases. were related with mild intoxication. The most serious intoxication was caused by barbiturates.

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MULTI FAMILY DISCUSSION GROUP IN EATING DISORDER INTEGRATED TREATMENT

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In the Eating Disorders Unit of the University Hospital "A. Gemelli" in Rome, Italy, we provide a protocol wich include multifamily discussion group, besides, individual psychoterapy, family therapy, and of course medical assistance.

Objectives: The aim of this group is to share and reflect on the difficulties that have arisen within families due to the behavior of their daughthers and try to find a shared understanding of common problems. We did use F.K.S. Family Perceived Climate Scale (Schmilatt and Rinke 1982) at the beginning and at the end of the treatment. This questionare is costituited by 49 questions that compose 11 scales.

Methods: The groups are composed of about five couples and are lead by a couple of therapists; the sessions occur every two weeks and least 90 minutes. The parents are invited to discuss as free as possible any topic they consider relevant.

Results: Confrontating the data of the singles subscales of the F.K.S. at the beginning and at the end of the treatment we have noticed that the family gives lower points at the 11 scales. Group experience besides lead to an improvement of daughthers compliance of therapeutic project. We hypothesize that it can be due to the emergency of parents own emotional needs. And this lead to a better protection of patient's therapeutic setting from parents' intrusion.

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