

legal capacity). At the end of the year there was a slight decrease of current clinical (1.96 ( $\pm$  1.5)) and social (1.46 ( $\pm$  2.1)) problems. Analyzing patients' individual courses during the 1 year-period the level of social skills and abilities is much more stable than the clinical level of functioning with its considerable fluctuations (esp. concerning neuroleptic side-effects, destructive and socially embarrassing behaviour). Studying the contents of the normative needs for care rated by professionals with a factor analysis the main field during the 1 year-period shifts to items of care resulting from disabled social competences. On the other hand the part of psychiatric needs for care growing from schizophrenic disorders' typical symptoms loses a great deal of its significance. - Besides correlations with data on former hospitalizations ( $r = .28$  to  $.39$ ) and psychopathological characteristics ( $r = .34$  to  $.61$ ) the needs of care especially in the social sector are higher for men and for patients living in their family of origin and in sheltered homes ( $p = .011$  resp.  $p = .000$ ). - The general level of unmet needs and not meetable needs in the examined group of patients ranges from 5–11% in the community psychiatric care structure of the Dresden area. The main fields here are: leisure-time activities, occupation/employment and social interaction skills. In each of these this is partly due to not yet established community-orientated institutions of care.

### Wed-P19

#### UTILITY OF AN ACCURATE ASSESSMENT OF THE AGE OF ONSET IN SCHIZOPHRENIA

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**Aims:** An accurate assessment of the age of onset in schizophrenia could be necessary in research, in particular in studies on pre-morbid adaptation, pre-morbid personality disorders or anticipation. The aim of this study was to assess the interest of using a standardized interview to determine the age of onset in schizophrenia.

**Methods:** 65 schizophrenic patients aged between 18 and 42 were included. We elaborated an original interview based on DSM-IV criteria which enabled us to determine retrospectively the date of onset of the first psychotic symptom present for at least one month, or of a marked socioprofessional deterioration. Patients and their mothers were interviewed separately and we examined the medical records. To determine the age of onset in schizophrenia, we took into account the earliest age of onset of psychotic symptoms or socioprofessional deterioration mentioned by the informants and the medical records.

**Results:** Reliable assessments were realisable for 96.9% patients (63/65). The age of onset of schizophrenia was consistent with patients answers in 79.2% of cases, with mothers answers in 73.0% of cases, and with medical records in only 39.6% of cases. The mean age of onset assessed by the interview was significantly lower than the mean age of first hospitalisation (19.6  $\pm$  4.9 vs 23.0  $\pm$  4.7 years;  $p < 0.001$ ). The difference between age of onset and age of first hospitalisation was significantly greater in progressive than in acute onsets (4.6  $\pm$  3.0 vs 1.3 years  $\pm$  2.4;  $p < 0.001$ ).

**Conclusion:** the use of a standardized interview to determine the age of onset of schizophrenia seems to bring more reliable and more accurate results than a simple examination of medical records particularly in progressive onsets.

### Wed-P20

#### CLINICAL DIMENSIONS OF AUDITORY HALLUCINATIONS: A FACTOR ANALYTIC STUDY

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**Material-Methods:** One hundred psychotic psychiatric inpatients with active auditory hallucinations were rated at admission on 20 item scales representing several important clinical features of auditory hallucinations, tested for their interrater reliability. Patients were also rated on the Brief Psychiatric Rating Scale (BPRS), the Hamilton Depression Rating Scale (HDRS) and the Mini-Mental State Examination (MMSE).

**Results:** A Principal Component Analysis of patients' scores on the 20 item-scales resulted in the extraction of eight factors, jointly accounting for 63.3% of the variance. These factors were interpreted as representing the dimensions of length of hallucinatory occurrences ( $F_1$ ), emotional and behavioral concern ( $F_2$ ), changeability ( $F_3$ ), rate of hallucinatory occurrences ( $F_4$ ), delusional elaboration ( $F_5$ ), similarity to normal auditory perception ( $F_6$ ), verbal comprehension ( $F_7$ ) and volitional dyscontrol ( $F_8$ ). Most of the factors were found to exhibit distinctive profiles of anamnestic and clinical correlates. Thus,  $F_1$  was correlated with longer duration of illness and lower score on the BPRS,  $F_2$  with higher BPRS score and shorter duration of illness,  $F_3$  with higher and  $F_4$  with lower number of hospitalizations respectively,  $F_5$  with longer duration of illness, lower number of hospitalizations and lower BPRS score and, finally  $F_6$  with lower score on the MMSE.

**Conclusions:** Our results provide for the first time supportive evidence for the multidimensionality of auditory hallucinations at the factor analytic level as well as for the partial external validity of the factorial solution obtained. Furthermore, they are in agreement with those of other studies showing the differential response of various components of auditory hallucinations to treatment with antipsychotic drugs as well as their distinctive course over time.

### Wed-P21

#### CLINICAL DIMENSIONS OF DELUSIONAL BELIEFS: A FACTOR ANALYTIC STUDY

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**Material-Methods:** We studied 12 formal clinical characteristics of delusional beliefs in 127 psychiatric inpatients with delusions at admission by means of 3-point ordinal rating scales, tested successfully for their interrater reliability. Patients were also rated on the Brief Psychiatric Rating Scale (BPRS), the Hamilton Depression Rating Scale (HDRS), the Global Assessment Scale (GAS) and the Mini-Mental State Examination (MMSE).

**Results:** A Principal Component Analysis of patients' scores on the 12 item scales yielded five factors which jointly accounted for 62.7% of the variance. These factors were interpreted as representing the dimensions of cognitive disintegration ( $F_1$ ), doxastic strength ( $F_2$ ), subjective concern ( $F_3$ ), referential and affective incongruence ( $F_4$ ) and delusional expansiveness ( $F_5$ ). Moreover these five factors were found to exhibit to a large extent distinctive profiles of demographic, anamnestic and clinical correlates. Thus,  $F_1$  was associated with male gender, longer duration of illness and lower MMSE score,  $F_2$  with shorter duration of illness and lower number of hospitalizations,  $F_3$  with higher BPRS scores,  $F_4$  with

younger age and lower HDRS and GAS scores and, finally, F<sub>5</sub> with shorter duration of illness.

**Conclusion:** Our results provide supportive evidence for both the clinical multidimensionality of delusional beliefs at the factor analytic level and the external validity of the factorial solution obtained. Different solutions obtained by other investigators (Kendler et al 1983, Garety and Hemsley 1987) are compared to ours and commented upon as well.

### Wed-P22

#### FUNCTIONAL CHANGES IN MESIAL TEMPORAL LOBE STRUCTURES IN SCHIZOPHRENIA. MEASUREMENTS BY SIMULTANEOUS <sup>18</sup>FDG AND <sup>99m</sup>Tc HMPAO SPECT

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The aim of this study was to investigate the simultaneous pattern of glial and neuronal activities in chronic schizophrenic disorders in the mesial temporal lobe by analyzing the regional cerebral glucose metabolism (rCMR), the regional cerebral blood flow (rCBF) and the influence of gender. 19 medicated patients (7 females/12 males, mean age F 40.4a ± 13.2 and M 36.25a ± 11.9) meeting ICD 10 diagnostic criteria for the schizophrenic syndrome F 20.04 and 9 healthy volunteers comparable in age and in handedness (4 females/5 males, mean age F 36a ± 8.9 and M 39a ± 10.4) underwent a simultaneous <sup>18</sup>FDG and <sup>99m</sup>Tc HMPAO SPECT. We used a dual head camera with a 511 KeV collimator applying the double isotope technique. Assuming an involvement of the temporal regions in this illness (Friston et al. 1992, Gur et al. 1995) we semiquantitatively evaluated activities in the hippocampal region (hipp) based on Podreka's analytical method. (Fritzsche et al. 1995). The statistical analyses were performed by regression analysis and ANOVA. Schizophrenic males showed a positive correlation of rCBF and rCMR on the right (p < 0.03) and left side (p < 0.05); controls (M) revealed only a weak correlation on the left hemisphere (p < 0.06). Schizophrenic females however had only a marked left-sided correlation of rCMR and rCBF (p < 0.02); for F controls no correlation was recorded. Thus, rCMR on the right hemisphere of healthy controls seems to be sex-dependent (F 96.6% ± 3.5 vs M 103% ± 2.4; p < 0.01). Conversely, in schizophrenia sex dependence relates to the left hipp only, as shown by rCMR (F 88.7% ± 9.7 vs M 97.4% ± 7.1; p < 0.05) and more strongly by rCBF (F 95.4% ± 3.5 vs M 104.8% ± 7.1; p < 0.007). Although there are limitations to our study, the results suggest a distinctly sex dependent functional involvement of the mesial temporal lobe in chronic schizophrenic patients, as recorded by rCBF and/or rCMR.

### Wed-P23

#### A RISPERIDONE OUTCOME GUARANTEE PROJECT — EFFICACY AND QUALITY OF LIFE OF SCHIZOPHRENIC PATIENTS IN LONG-TERM TREATMENT WITH RISPERIDONE

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This study aims at assessing long-term management of chronic schizophrenia when treated with risperidone by consecutive documentation of severity of symptoms, therapeutic efficacy, adverse events, social functioning and activities of daily living (documented by QoL questionnaires and CGI). In addition, the Outcome Guarantee Project involved a guaranteed refund of treatment costs

by the drug manufacturer in case of treatment failure defined as rehospitalization or withdrawal due to adverse events.

117 patients with acute or chronic schizophrenia were enrolled in this project to receive risperidone for 1 year. The mean dose of risperidone in a first analysis after 4 weeks of treatment was 4.4 mg/day. 70% of patients already completed the 1 year period, for the remaining 30% the trial is still ongoing.

The patients were treated either in the psychiatric hospital department or by one of 23 office-based psychiatrists participating in the project.

At the end of 1 month treatment, significant improvements were found in the severity of disease, symptoms and therapeutic efficacy, the severity of adverse events was also reduced. The same improvements were noted after 1 year and, in addition, social functioning and activities of daily life (including shopping, watching TV, going out, doing sports, taking public transport, etc.) were substantially improved.

3 patients have prematurely terminated treatment (1 due to an adverse event, 2 because of lack of efficacy and rehospitalization). All three of them were unanimously considered to be guarantee cases. The number of sick leaves (evaluated retrospectively) and days spent in hospital was substantially reduced during treatment with risperidone.

It is concluded that treatment with risperidone for 1 year is associated with significant reductions in symptoms of schizophrenia, improved social functioning and activities of daily life, and reduction in days spent in hospital.

### Wed-P24

#### A CLINICAL APPROACH OF NEGATIVE SYMPTOMATOLOGY IN SCHIZOPHRENIA

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Negative symptoms in schizophrenia could be considered from different points of view:

- a syndrome;
- a mode of onset of schizophrenia;
- a subtype status of this illness.

The characteristics of a negative syndrome are: blunted or restricted affect, poverty of speech, loss of drive, social and emotional withdrawal, anhedonia, apathy. There are primary negative symptoms and should be a direct manifestation of the pathologic process. Poor grooming and impaired social relationship could be appreciated as secondary negative symptoms. DSM IV and ICD-10 include in criteria A (characteristics symptoms) for schizophrenia these negative symptoms. There are similarities between schizophrenic patients from various cultures and these are represented mainly by negative symptoms. N. Andreasen proposed as subtypes of schizophrenia: "pure negative", "pure positives" and mixed. Crow considered that poverty of speech and blunted affect are associated with intellectual impairment, abnormality in the temporal lobe in type II schizophrenia. Diagnostic criteria for the deficit Syndrome of Schizophrenia (Carpenter) include at least two of the following negative symptoms:

- restricted affect;
- poverty of speech
- deficit of social participation;
- diminished emotional range;
- diminished social drive;
- diminished of interests.

An clinical and therapeutic approach of these negative symptoms would be useful in psychiatric practice. We consider this division as necessary especially in the treatment with atypical