legal capacity). At the end of the year there was a slight decrease of current clinical (1.96 (± 1.5)) and social (1.46 (± 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 shiftes 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 premorbid adaptation, premorbid 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 +/– 4.9 vs 23.0 +/– 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 +/– 3.0 vs 1.3 years +/– 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 inconguence (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

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