

No doubt, the deinstitutionalization has been a benefit for a good deal of the mentally disordered, however, a row of negative indicators suggests that not all of the most severe mentally ill are winners:

- increasing number of criminal mentally ill
- increasing SMR among the psychotics
- increasing use of coercion in the wards
- increasing number of occupied beds in the wards

With Denmark quoted as an example it is documented that for some patient groups the decentralization might have gone too far and in any case too fast. There are hopes of a more positive development in the next few years, gauged by a braking of the disintegration of institutions, establishment of others, respect for mentally illnesses as brain diseases, and by specialization and centralization of treatment functions.

SEC40-3

QUALITY OF LIFE FOR PATIENTS IN THE COMMUNITY

H. Katschnig, *Department of Psychiatry, University of Vienna, Austria*

Institutionalisation, depersonalisation and removal of the psychiatric patient from his social network were the characteristics of asylum psychiatry at the turn of the last century. One hundred years later, de-institutionalisation, personalization and re-insertion of the patient into the community are the declared aims of official mental health policy. What is the difference for the patient's quality of life? Quality of life is not yet a clear and well-defined concept, although it has an intuitive appeal to most people. Who would not like to experience a good quality of life? If quality of life is equated with the fulfilment of needs, a first approximation would be to use Maslow's hierarchy of human needs, starting with the most basic physiological needs for food and shelter and leading over belonging needs to psychological and finally self-actualization needs. No doubt, asylum psychiatry has fulfilled the most basic physiological needs, but has neglected psychological and self-actualization needs, especially some of the most valued needs, that for autonomy and for being part of society. Community psychiatry, on the other hand, tends to fulfil the latter needs, often - as it seems - at the expense of the more basic physiological needs, as the many homeless people on our streets seem to tell us. Recent research, however, shows an astonishingly high degree of satisfaction among patients moved from the hospital to the community, even if material life circumstances seem less satisfying to an ordinary person. Autonomy and participation in community life, although still limited for many patients living in the community, are higher valued by the majority of patients than the material security of the hospital environment - at least once experiences could be gathered with living in the community. A limiting factor for gaining full autonomy and participation in community life is not so much the residual disability - due to the specific mental disorder or due to the effects of institutionalisation - but what can be called the "stigma dilemma": Perceived stigma is a strong determinant of subjective quality of life, as recent research has shown. As a rule psychiatric patients living in the community receive help in terms of treatment and material assistance by declaring themselves as patients and accepting the role of the mentally ill. At the same time, accepting this role carries a societal stigma with it, which excludes these patients from normal life, from "being part of us". The dilemma "help and stigma" or "no help and no stigma" would already be impossible to solve for a healthy person. We have to be very creative in order to overcome this major obstacle to improving the quality of life of patients in the community.

SEC40-4

THE IMPACT OF COMMUNITY CARE UPON FAMILIES

A.H. Schene*, B. van Wijngaarden. *Department of Psychiatry, Academic Medical Center/University of Amsterdam, The Netherlands*

More than a century ago institutionalization of psychiatric patients was started. Arguments for this were not only the possible benefits of care and treatment for the mentally ill. For this hospitalization movement relieving families and protecting society were just as important. Nowadays most countries try to find a balance between caring for patients at the one hand and caring for the society, and more in particular for family members, at the other. We aim at good community care.

During the last ten years we have been studying the consequences of being a family member or close relative of someone with a mental disorder. We developed the Involvement Evaluation Questionnaire, a 78-item instrument to measure the impact of mental disorders for relatives or caregivers. With this instrument we studied the impact of caregiving for families of patients with schizophrenia (N = 680) and depression (N = 260).

For both groups of families factor analysis showed 5 factors: tension, supervision, urging, worrying and finances, and a totalscore with an alpha of .90. In this paper the influence of patient, family member and interaction characteristics on the amount of caregiving consequences will be discussed for both patient groups. Different initiatives to reduce family burden will be shown especially in relation to developments in Dutch community mental health care.

SEC40-5

DEINSTITUTIONALISATION AND SCHIZOPHRENIA IN FINLAND. RESULTS OF THE DSP-PROJECT

R.K.R. Salokangas¹*, T. Honkonen². ¹*Department of Psychiatry, University of Turku, Turku;* ²*Department of Psychiatry, University of Helsinki, Helsinki, Finland*

Finland has experienced one of the most rapid psychiatric deinstitutionalisation processes in the whole world. Since 1980, the use of psychiatric beds has decreased about two thirds. The effects of this process was studied in a national study project of the Discharged Schizophrenic Patient by three representative samples of schizophrenic patients discharged from Finnish mental hospitals in 1982, 1986 and 1990. In all, 3 300 patients were studied and followed for three years.

The in 1990 discharged schizophrenic patients were older, more disturbed and had been ill for longer time than at the beginning of the 1980s discharged patients. The use of out-patient care increased and that of hospital care decreased but because of the increased residential out-patient care the total amount of residential care did not change during the study period; re-admissions to hospital increased, however. In the patients with a long duration of illness the increase of re-admissions was exceptionally high; they also seemed to be losing their share of the residential out-patient services. The patients discharged in 1990 were more often living alone than the patients discharged earlier. However, their housing conditions were comparable with those of the general population and homelessness was rare. At the follow-up, the patients were more satisfied with their life than at the discharge.

On the whole, the deinstitutionalisation process seemed to have proceeded fairly successfully from the point of view of the psychiatric treatment system. It proved to be able to re-direct and use the resources available more effectively and modify the structure of services according to the changing needs of patients discharged from hospitals. The discharged patients had found rather good

living conditions in the community. The well developed social services have also supported this adaptation to the decreasing use of mental hospital beds. Further changes will be studied with the new patient cohort discharged in 1994.

S41. Neurobiology and pharmacotherapy of impulsive behaviour

Chairs: W Maier (D), H Sass (D)

S41-1

PSYCHOLOGICAL AND PSYCHOPATHOLOGICAL CONCEPTS OF IMPULSIVENESS AND IMPULSE CONTROL DISORDERS

S. Herpertz*, H. Sass. *Rheinisch-Westfaelische Technische Hochschule Aachen, Germany*

A deficit of impulse control is discussed in an increasing number of mental disorders. One of the major problems in examining impulsiveness in clinical settings, however, is a lack of conceptual framework which aims at a scientific definition of impulsiveness. Current classification systems restrict impulsiveness exclusively to impulsive modes of behavior. Psychology has a broader concept as it regards impulsiveness as the enduring tendency to respond quickly and impetuously to a stimulus rather than inhibiting the response. A study design will be presented providing data on different aspects of impulsiveness in a sample of N = 122 personality disordered subjects with different impulsive modes of behavior. Findings indicate that impulsiveness is not restricted to single impulsive events but reflects a pervasive long-term functioning including an irritable, aggressive behavioral style, a lack of future-oriented problem-solving, difficulties to shift between cognitive sets as well as intense responding to emotional stimuli. Finally a concept of impulsive personality functioning is suggested which includes emotional and cognitive beside behavioral phenomena.

S41-2

TESTOSTERONE AS AN INDICATOR OF AN ALTERED 5-HT RESPONSIVITY IN AGGRESSIVE SUBJECTS

P. Netter*, J. Hennig, B. Meier, S. Rohrmann. *Dept. of Psychology, University of Giessen, Germany*

There is evidence that serotonin (5-HT) does not only stimulate cortisol via the HPA axis but also suppresses testosterone via the gonadal axis. Since high testosterone levels and responses as well as low serotonin activity have also been shown to be related to dispositional and experimentally induced aggression, the investigation of the relationship between 5-HT and testosterone by two experiments on aggression in humans seemed a promising approach.

The first study comprised 40 male subjects randomly assigned to experimental induction of aggression or a control condition as well as to the 5-HT_{1A} agonist ipsapirone or placebo (n = 10 in each subgroup). In Study 2 ipsapirone was compared to placebo during 2½ hours of boredom in 20 males each. In both studies groups were divided according to questionnaire scores into high and low aggressives and testosterone, cortisol, and emotional states were assessed.

The major results showed

1. Induction of aggression increased testosterone and aggressive emotions and behavior, and this was more pronounced in high aggressive subjects.
2. The 5-HT agonist ipsapirone reduced testosterone, but this was less pronounced in high aggressives, and high testosterone responders showed more pronounced aggressive behavior. A cortisol increase upon ipsapirone only occurred when high testosterone responders were exposed to aggression induction.
3. Subjects divided according to autoaggression and overt aggression showed opposite patterns of hormone responses.

Results are interpreted with respect to differences in pre- and postsynaptic sensitivity for 5-HT_{1A} receptors related to hetero- and autoaggression and manifested by differences in testosterone and cortisol responses.

S41-3

COGNITIVE PSYCHOPHYSIOLOGY OF IMPULSIVITY AND LOSS OF CONTROL

R. Jouvent*, A. Pierson. *CNRS UMR 7593, Hôpital de la Salpêtrière, 75013 Paris, France*

The heterogeneity of depressive disorders generates as many subtypes as clinical pictures encountered. For this reason, we characterized patients on phenomenological criteria and, in addition to the global score of depression, we considered negative (psychomotor retardation and blunted-affect) and positive (anxious agitation and impulsivity) symptomatology. These dimensions do not overlap with a specific clinical type of depression. In patients fulfilling the DSM III-R criteria for major depressive episode, we have shown that such opposed subgroups exhibited specific information processing characteristics, as indicated by ERP parameters. In a go-nogo task, only anxious-agitated and impulsive (AAI) patients showed an abnormal activation (high CNV) during expectation of the stimulus which was not pertinent for the task (nogo condition) in comparison with retarded and blunted-affect (RBA) patients. In a choice forewarned reaction-time task with both stimuli each containing some part of the information necessary for giving the response, P3a amplitudes were reduced in all patients compared to controls whereas P3b components were reduced in RBA patients whereas only P1-N1 peak-to-peak amplitudes were reduced in AAI. These differences in energetical processes may explain differences in speed of processing: a slow encoding of stimuli (P1 latency) and a prolonged processing of stimulus-response compatibility (after P3b) observed in all patients was compensated by a global velocity increase in decision making (P3b latency) in AAI patients or, the contrary, cumulated with its velocity decrease in RBA patients. The impairment in anxious-agitated patients seems to be limited to perceptual processes contrary to blunted-affect patients whose the multiple energetical deficits seem to indicate that they result from an impairment of a more general process such as effort. As a whole these results may explain the massive behavioral retardation observed in blunted-affect patients, as indicated by Rts, and contrary to anxious-agitated patients who show normal reaction times. General considerations will be then developed, concerning extensive value of our results to various impulsive behaviors.