GLUTAMATERGIC BRAIN SYSTEMS AND ADDICTION

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Excitatory amino acids (EAA) play a dominant role in the central nervous system as excitatory neurotransmitters. Animal and human data indicate that EAAs, especially L-glutamate, are involved in the development of alcohol dependence and craving. EAA actions implicated in the tolerance to and dependence on ethanol probably involve the activation of the genome. Chronic alcohol treatment increases the density of NMDA receptors and voltage-sensitive Ca^{2+}-channels in neurons. Inhibitory $GABA_A$ receptor-mediated actions are reduced. These changes provide a plausible explanation for the hyperactivity observed during alcohol withdrawal, that resembles in some respects grand mal seizures. There is evidence that the repeated occurrence of withdrawal seizures leads to a more rapid development of withdrawal and more severe withdrawal syndromes. Neuronal hyperactivity during withdrawal may induce, in various target areas, the activation of transcriptional modulators encoded by immediate early genes through kindling-like mechanisms. It is reasonable to assume that individuals may ingest alcohol to avoid the negative consequences of abstinence that result in neuronal hyperactivity.

Acamprosate, which has proven its efficacy in relapse prevention in a comprehensive treatment setting, reduces neuronal excitability by reducing the postsynaptic efficacy of excitatory amino acid (EAA) neurotransmitters. Apparently GABAergic inhibition is not enhanced by acamprosate. Acamprosate has been shown to be devoid of hypnotic, anxiolytic or muscle relaxant properties distinguishing it from barbiturates and benzodiazepines. There is no evidence of any antidepressant or other psychotropic effect. Acamprosate reduces the expression of transcriptional modulators encoded by immediate early genes and the expression of genes coding for EAA receptor subunits in withdrawal and post-withdrawal periods. Through such actions acamprosate could counteract the long-lasting changes in latent neuronal hyperexcitability following chronic alcohol abuse. The possible mode of action of acamprosate, e.g. at allosteric sites located on the extracellular domains of EAA receptors, is still under evaluation.

S9. Clinical services for mentally ill childbearing women

Chairmen: C Kumar, I Brockington

PERINATAL PSYCHIATRY IN FRANCE

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In 1858, Louis Victor Marcé published his "Traité de la folie des femmes enceintes, des nouvelles accouchées et des nourrices"[1], which represented, after the historical article by E Esquirol [2], the first extensive account of perinatal psychopathology. However, interest in this topic in France subsequently seems to have diminished since then.

The first mother-baby hospitalization in France occurred after World War II under the direction of P C Racamier, whose publication on motherhood and puerperal psychosis became a major reference and landmark for French psychiatrists [3]. Although Racamier is a general psychiatrist, most professionals currently involved in perinatal psychiatry are child psychiatrists, nearly all of them psychoanalysts. The last 15 years have seen the development of infant psychiatry by groups of S. Lebovici, R. Diatkine, M. Soulé etc. A few mother-baby units have been opened, all run by child psychiatrists. In 1995, there were 28 mother and baby beds in France and interest in perinatal psychiatry is expanding.

We shall review clinical practice and its theoretical background in French clinical psychiatric services for mothers and babies. We shall also present our own experience and practice, based mostly on liaison psychiatry in the maternity wards of a University Hospital, and on admissions of mothers and babies into the adult psychiatry department.

[1] Marcé LV (1858) Traité de la folie des femmes enceintes et des nouvelles accouchées et des nourrices. Paris: Baillière et fils.
[2] Esquirol E (1838) Des maladies mentales. Paris: Baillière.
[3] Racamier PB, Sens C, Carretier L (1961) La mère et l'enfant dans les psychoses dans les psychoses du postpartum. Evolution Psychiatrique 46: 525–570.

TRANSCULTURAL ASPECTS OF PERINATAL PSYCHIATRY

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This paper will indicate the extent to which a full grasp of sociocultural variables is particularly necessary for an understanding of the predisposing, precipitating and maintaining factors of perinatal mental disorders.

The specific contribution of Medical Anthropology to this field is acknowledged and especially the relevance of the psychosocial support associated with Postnatal Rituals and Taboos, the impact of a Naming Ceremony in Uganda, and whether Postnatal Depression should be construed as a Disease entity or a folk label.

The paper will report transcultural studies carried out by the author in this field which have included comparative studies of PND in Uganda and Scotland, an account of Culture Bound Puerperal Psychosis (Amakiro), ongoing studies of the frequency of PND in North Staffordshire (the Potteries) and the relevance of understanding local sociocultural variables as they relate to aetiology and treatment.

The neglect of services for depression amongst Ethnic Minority Groups, and in particular those for which a knowledge of the English language is insufficient, will be highlighted. With appropriate clinical and research caveats suggestions for developing a more culturally sensitive clinical service and assessment procedures will be outlined.

The proposed International Transcultural Study of Postnatal Depression coordinated by Professor Kumar and myself will be described, and support solicited from interested Research Centres.

A sociocultural model of mental disorder is fundamentally necessary to a full understanding of Perinatal Psychiatric Disorder alongside the explanatory models from Biological Sciences and Psychology.

MENTAL HEALTH SERVICES FOR WOMEN FOLLOWING CHILDBIRTH

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Postnatal mental illness is common and much of it serious. In addition childbirth poses a major risk to the mental health of women with serious mental illness. Without prompt and appropriate management, the consequences for the mother and her infant may be grave.

The rates of psychiatric disorder following childbirth are now well established. Ten per cent from all women delivered will suffer a new episode of major depressive illness, between three and five per cent severe enough to warrant psychiatric treatment. 1.7% will be referred to a psychiatrist, 4 per thousand admitted to a psychiatric hospital

and 2 per thousand admitted suffering from a puerperal psychosis. Once the birthrate of a health district is known the local psychiatric morbidity is easily estimated. Even in the smallest health district there will be sufficient workload to justify special interest consultant sessions. The clinical characteristics, health needs and patterns of service usage are sufficiently distinctive to justify a specialist service.

Despite this few centres in the UK offer even mother and baby admission and even fewer comprehensive and integrated care.

The information needed for a local health needs assessment exercise and the formula for estimating the necessary resources is given. Different models of service delivery appropriate to local circumstances are described.

The General Psychiatry Section Working Party on postnatal mental illness recommends that all suffering from psychiatric disorder following childbirth should have access to a consultant with a special interest in their condition and specialist community psychiatric nurses. When necessary such patients should have access to specialist inpatient mother and baby beds.

PERINATAL CARE AND MATERNAL WELL-BEING IN THE NETHERLANDS

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Generally speaking, in The Netherlands, there are three patterns of peripartum care: antenatal consultations and birth at home with the aid of a community midwife (or occasionally a general practitioner); a '24-hour confinement' (parturition in hospital with the aid of the person who provided the antenatal care — community midwife, general practitioner or obstetrician — with the mother leaving the hospital within 24 hours); and a 'clinical' confinement (parturition in hospital with the mother remaining for more than one day — generally 5 to 7 days — when there is a medical indication). Up to 35% of the women deliver their baby at home. After parturition, a 'perinatal' health nurse stays with the mother during the day for one week teaching the (new) mother how to cope with the newborn. At six weeks' postpartum there is a final consultation with the person who provided antenatal care. There is, however, a lack of inpatient facilities for admitting mothers and babies jointly when mothers are psychotic.

This system of clinical care allows one to examine psychiatric outcome in dyads with elective normal deliveries in hospital and at home. Although no differences in outcome were found assessing mood at 4 weeks' postpartum, recently, assessing mood during the first postpartum week, the occurrence of blues and depression (EPDS) was found to be related to deliveries at home or in hospital.

S10. Attitudes towards antipsychotic medication

Chairmen: E Hoencamp, J Gerlach

PATIENTS SUBJECTIVE EXPERIENCES ON ANTI-PSYCHOTIC MEDICATIONS — IMPLICATIONS FOR OUTCOME AND QUALITY OF LIFE

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Clinicians have frequently observed that some of their schizophrenic patients experienced a change in subjective state often following only a few doses of a neuroleptic. Complaints ranged from "feeling like a Zombie", the inability to think straight, and the notion that the medications are worsening their condition. Such phenomena have been invariably labelled as neuroleptic dysphoria, akinetic depression, behavioral toxicity, neuroleptic decompensation, etc. Not surprisingly, a number of patients experiencing such negative subjective responses to neuroleptics continually complain about the medications, and place pressure on their clinicians to frequently change them. It is not uncommon for many to discontinue their medication themselves, leading to relapse and frequent hospitalizations.

This presentation will review the concept of subjective response to neuroleptics, the validity of the construct, its measurement as well as its relevance to therapeutic outcome. Data will be presented to link negative subjective response to compliance, less favourable clinical outcome, to concomitant illicit drug abuse (comorbidity) as well as its association with some cases of suicide. The predictive value of early subjective response in treatment outcome has been validated in a number of studies.

In schizophrenia, as in any other chronic illness that requires long-term therapy, what is important for patients is how they feel and function on medications. In that sense the impact of neuroleptics on the functional status becomes an important consideration, not only from the clinical aspect but also for the development of new neuroleptics. Data will be presented to confirm the contribution of negative subjective responses to the construct of quality of life in medicated schizophrenics.

NEUROLEPTIC-INDUCED DEFICIT SYNDROME, DEPRESSION AND NEGATIVE SYMPTOMS IN SCHIZOPHRENIA

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The differentiation between depressive features, negative symptoms, and neuroleptic side-effects, such as the putative neuroleptic-induced deficit syndrome (NIDS), in patients with schizophrenia may have significant implications for treatment and management. The problems in assessment include the degree of phenomenological overlap, particularly with regard to dysphoric symptoms, and the lack of precise operational definitions, particularly for negative symptoms and the NIDS. The NIDS incorporates adverse subjective experiences as well as objective measures, such as cognitive impairments, and behavioural deficits such as apathy and lack of initiative. The diagnostic process is further confounded by the need to distinguish between primary negative symptoms as persistent, enduring deficits, and social and emotional withdrawal secondary to positive symptoms, or related to depressive features or drug-effects such as sedation and the bradykinesia component of parkinsonism.

Clinical discrimination between these elements is likely to require careful observation of patients with schizophrenia, over time, by trained raters using appropriate rating scales for depression and negative symptoms that are sensitive to change. Ratings of patients' subjective experiences regarding mood may have discriminatory value in clinical practice. Patients' awareness of behavioural and cognitive deficits, should also be included in view of their possible relationship with social functioning and vulnerability to depression. The associations between the subjective data and the objective ratings of depression, negative symptoms and drug side-effects may help in the clinical discrimination of these areas of dysfunction and also the refinement of their phenomenological descriptions.