interviewing often does not lead to a diagnosis of social phobia, because these persons do not seem to be inclined to regard their objectively restricted life as especially burdening, whereby the impairment criterion required by operational diagnostic criteria is not fulfilled. However, persons suffering from social phobia are restricted in many aspects of their life: they are socially isolated, less well educated, less productive in work and impaired in many other aspects. However, because of the usually long duration of the disorder before it is recognised, for social phobia has become a "way of life" for many sufferers. Since social phobia is an early onset disorder - the generalised subtype has an age of onset of around 15 - an important component of the reduction of patient's quality of life seems to be due to the lack of social skills which are usually acquired in late adolescence and early adulthood. Due to the avoidance of social learning situations at this life stage disabilities develop and contribute to the reduction of functioning in social roles and prevent the creation of an adequate living environment, i.e. an adequate standard of living. Persons suffering from specific social phobia (e.g. performance anxiety) seem to be less disabled than those suffering from the generalised subtype. Early recognition, already at school age and in non-psychiatric services (e.g. in primary care), is the most important strategy for reducing the prevalence of social phobia.

## S32-3

### FAMILIAL AGGREGATION AND HIGH RISK STUDY OF SOCIAL PHOBIA

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This paper presents the results of a family study of comorbidity of anxiety disorders and alcoholism. The 165 probands were selected from both treatment and community settings and best estimate diagnoses were assigned to 1053 adult first-degree relatives. After controlling for potential confounders such as age, sex and comorbidity in both probands and relatives, there was a strong degree of specificity of familial aggregation of anxiety disorders and of the specific subtypes of anxiety including social phobia and panic as well. Different patterns of co-aggregation of alcoholism with social phobia and panic were found, thereby suggesting different mechanisms for comorbidity of the subtypes of anxiety and alcoholism. The results of a prospective longitudinal study of the children of these probands will also be reported. Both the child and adolescent offspring of parents with anxiety disorders had significantly greater rates of anxiety symptoms, behavioral inhibition and anxiety disorders, as well as psychophysiologic indicators of anxiety, than those of either controls or other affected parental groups. The strong degree of specificity of transmission of anxiety disorders suggests that there may be underlying temperamental vulnerability factors for anxiety disorders which may already manifest in children prior to puberty.

## S32-4

### DEVELOPMENT AND ANXIETY DISORDERS: CONTRIBUTION OF FAMILIAL AGGREGATION

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Prospective follow-up studies are commonly used, in order to precise continuity or discontinuity between disorders according to the developmental approach. Family studies also may contribute to the knowledge of these links. Previous studies had demonstrated that there was a familial component involved in the pathogenesis of anxiety disorders such as separation anxiety disorders, social phobia, or simple phobia (Last et al., 1987, Reich and Yates, 1988, Fyer et al., 1995). Last observed differences between separation anxiety disorder and phobic disorder for maternal psychiatric history, and suggested that it could exist differences in familial aggregation of anxiety disorders in the two subgroups of anxious school refusing children.

**Objective:** We designed a study to test the existence of differences in familial aggregation between a group of children suffering from school refusal related to separation anxiety disorder and a group suffering from phobic disorder-based school refusal.

**Method:** Using a blind standardized diagnostic evaluation we compared parental lifetime psychiatric illness for the two groups of refusers.

**Results:** Increased prevalences of anxiety and depressive disorders were found in mothers and fathers of anxious school refusing children. Relationships between specific anxiety disorders in children and their parents revealed increased prevalences of simple phobia, and simple and/or social phobia among the fathers and mothers of phobic disordered school refusers, and increased prevalences of panic disorder and panic disorder and/or agoraphobia among the fathers and the mothers of separation anxiety disordered school refusers.

**Conclusion:** Our data showed the high prevalence of both anxiety and depressive disorders in fathers and mothers of anxious school refusers. Significant differences were observed in familial aggregation considering the subgroups of anxious school refusing children, supporting the distinctions of these two different subgroups.

## S32-5

### THE ROLE OF THE FAMILY IN EARLY STAGES OF GENERALIZED AND NON-GENERALIZED SOCIAL PHOBIA: A FAMILIY AND PROSPECTIVE LONGITUDINAL EPIDEMIOLOGY STUDY

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Social phobia is characterized by the fear/avoidance of situations where an individual who is subject to the evaluation of other persons fears that he or she will do something painful or will appear anxious. Motivated by previous studies about familial liabilities of social phobias, we wanted to elucidate the role of specific family factors in the development of social phobia.

In detail, we want to find answers to the following questions:

1. Can we confirm the results of previous findings of a higher rate of social phobia in first-degree relatives of social phobics?
2. Can our data support the distinction between generalized and nongeneralized subtypes of social phobia on the basis of family data?
3. Is there a relationsship between parental alcoholism and social phobia in their children?
4. Is specific parental rearing behavior associated with social phobia in children?

The findings which will be presented are based on a face-to-face interview family study. Subjects were predominantly mothers of 1053 14- to 17-year-old adolescents and young adults which have been examined in the first and second wave of the EDSP-Study, a prospective epidemiological study which investigates the prevalence, comorbidity and course of mental disorders in this age group. Social phobia and the addressed family factors were assessed using

the computer-assisted Munich-Composite International Diagnostic Interview (M-CIDI).

### S32-6
CLINICAL COURSE, PHENOMENOLOGY, AND SEQUELAE OF SOCIAL PHOBIA IN YOUTH

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This paper describes the diagnosis and phenomenology of social phobia in youth, with emphasis on the expression of symptomatology within a developmental context. Comorbid conditions (e.g., depression, selective mutism) and behavioral concomitants (e.g., school refusal) will be discussed. The sequelae of social phobia will also be described in the context of risk for secondary diagnoses, especially adolescent substance use disorders. In addition, data examining the role of parent-child interactions as a maintaining variable in the disorder will be discussed. Data from an ongoing NIMH trial examining the effectiveness of cognitive behavioral group treatment for adolescents will be presented, along with a discussion of the relative role of parents in the treatment process. Future directions for research in the area of prevention and combined psychosocial-pharmacologic trials will be discussed.

## S33. Setting off a chain reaction: an interdisciplinary educational programme for OCD

*Chairs*: P Mindus (S), S Andréewitch (S)

### S33-1
SETTING OFF A CHAINREACTION THE OCD SCHOOL, AN INTERDISCIPLINARY EDUCATIONAL PROGRAM

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Obsessive-compulsive Disorder (OCD) is manifested by stereotyped, repetetive, obsessions and rituals. OCD is among the 10 top causes of disability worldwide. It need not be. Although prognosis without therapy is poor (8 out of 10 of those untreated remain affected), with behavior and drug therapy, often in combination, 8 out of 10 get much better or well. Yet, OCD remains underdiagnosed and undertreated, which represents a formidable health problem in many Western countries.

In an attempt to bring about a change, we recently initiated a large scale educational program (the OCD School) for teams of psychiatrists and their non-physician co-workers. The faculty included a member of the OCD patient association Ananke, a behavioral therapist and three psychiatrists. The program is endorsed by the Swedish Psychiatric Association and has several aims and targets. The prime aim is, obviously, to increase the awareness of OCD and current treatment options. Second, to improve the professional management of OCD using an integrated approach. Third, to simultaneously train both physician and non-physician team members in both exposure and antiobsessional drug therapy.

The next important targets are the participants own colleagues within psychiatry and in related somatic disciplines in need of an update on OCD. For this purpose, we provide the participants with a kit (brochures, slides, etc) and a primer of presentation skills. At the best of our ability we prospectively monitor the results of this educational program with various parameters. Preliminary, this initiative has been very well recieved and has improved OCD recognition and management. At the time of the congress we expect to have gained worthwhile experience and also to present follow-up data.

### S33-2
THE OCD SCHOOL: THE PATIENT AND CONSUMER PERSPECTIVE

B. Gill-Larsson. *Ananke, Sweden*

I am an OCD patient although I now consider myself cured after suffering from the disorder for 20 years.

Some facts from my life with OCD:

- It took 7 years before I sought help.
- It took 19 years until I received correct treatment.
- My personal costs caused by OCD; approximately 500.000 Swedish crowns.
- The costs to the healthcare system and to society; I dare not think of!

Ananke is a charitable support group for those who are affected by OCD and their relatives. I have been a member almost from the beginning in 1989 when Ananke Sweden was started at the initiative of Per Mindus and I have served as chairperson for several years.

In the beginning of my time in Ananke it seemed most patients didn't get treatment for OCD at all. Things have gotten better but we have a long way to go before we can say that most OCD patients get adequate treatment. During the years working for Ananke the most frequent question from OCD-sufferers has been; "Where can I find a doctor or a therapist who knows something about OCD?"

The OCD School has made that question easier to answer. More similar initiatives are needed. Let's work together to spread the message that OCD is both common and treatable!

### S33-3
THE OCD SCHOOL: DIAGNOSTIC ASPECTS

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As mentioned in the introductory paper, OCD is one of the most common psychiatric disorders, yet it is often unrecognized and untreated. It is a paradox that once a diagnosis of OCD has been contemplated it is often an easy one to make, yet it is often not made at all or is considerably delayed. For this reason an important part of the OCD School is devoted to improving diagnostic skills.

Participants where introduced to tools for structured diagnostic interviews (SCID, axes I and II) as well as symptom rating scales including the Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Tic-disorder scales and self-rating scales. Each participant was given the task of applying the diagnostic tools on a chosen patient and later to present the results in class. Our hypothesis is that a relatively brief training in diagnostic skills will bear fruit in the form of significantly more OCD patients recieving a correct diagnosis. Our experience from 3 consecutive OCD School cycles and the spontaneus reporting from course participants indicates that our hypothesis holds true. Follow-up evaluation will be presented and issues of training and relevant diagnostic tools will be discussed.

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