the course and outcome of the alternate disorder in a prospective population-based study.

Method: Results will be presented from the Zurich Cohort Study. The initial community sample of 591 subjects was followed-up from age 20 to age 35. Each diagnostic assessment included a semi-structured interview which allowed the assignment of diagnoses according to 1) DSM-III criteria and 2) operational definitions of subthreshold syndromes. Course and outcome parameters were also measured at each follow-up. Course was described using both algorithmically defined patterns based on the diagnostic level of syndromes (threshold-subthreshold-absent) at each follow-up and graphic patterns that were presented to the subjects at the last follow-up.

Results: The weighted lifetime prevalence of a threshold depressive syndrome with comorbid threshold or subthreshold anxiety was 5.9% and 7.4%, respectively. The lifetime prevalence of threshold anxiety with comorbid subthreshold depression was 3.2% and that of combined subthreshold depression-anxiety was 4.6%. The presence of a comorbid syndrome, regardless of whether or not it reached threshold, was found to be associated with poor course and outcome in terms of chronicity, recurrence, duration of suffering, work impairment, need for treatment and the risk of suicide attempts.

Conclusion: Our study confirms the negative impact of comorbid depression and anxiety on the prognosis of each index disorder. Furthermore, we could demonstrate that it is not necessary for the comorbid condition to meet full diagnostic criteria in order to achieve this effect; indeed, subthreshold anxiety and depressive syndromes are predictors of poor course and outcome of the alternate disorder.

FC51-3
PREDICTORS OF MULTIPLE COMORBIDITY IN PATIENTS WITH PANIC DISORDER AND AGORAPHOBIA

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Objective: To examine predictors of multiple comorbidity (comorbidity with more than one other anxiety and/or mood disorder) in patients with panic disorder and agoraphobia (PDA).

Method: Comorbidity with other anxiety and mood disorders was determined in 60 consecutive patients with a principal diagnosis of PDA by means of the Structured Clinical Interview for DSM-III-R (SCID), modified for DSM-IV. Logistic regression was used to identify predictors of multiple comorbidity. Dependent variables were lack of comorbid diagnosis + one comorbid diagnosis as one group, and more than one comorbid diagnosis (multiple comorbidity) as the other. Independent variables were demographic variables (age, sex, marital status, educational level), duration of PDA, presence of a personality disorder (as determined by the Structured Clinical Interview for DSM-IV Axis II Personality Disorders, SCID-II), and variables from instruments (Parental Bonding Instrument, Separation Anxiety Symptom Inventory and Child Abuse and Trauma Scale) which assess patients' perception of their parents and childhood separation and traumatic experiences.

Results: The overall comorbidity rate in PDA patients was 85%, and rate of multiple comorbidity 67%. Logistic regression of predictors was statistically significant (chi-square = 21.68; p = 0.041; odds ratio = 2.61), and diagnosis of a personality disorder emerged as the only statistically significant predictor of multiple comorbidity (B = 2.67; p = 0.011; odds ratio = 14.51).

Conclusions: The finding that presence of (any) personality disorder is the best predictor of multiple comorbidity in patients with PDA has several implications. In terms of etiologic relationships, personality disturbance may predispose to more than one anxiety and/or mood disorder; conversely, personality disorders may complicate several interrelated anxiety and/or mood disorders. Presence of personality disturbance may complicate treatment of PDA in such cases also because of greater likelihood of association of PDA with several other disorders.

FC51-4
TREATMENT OPTIONS IN SOCIAL PHOBIA

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Social phobia is now recognised as a chronic and disabling psychiatric condition that is frequently comorbid with depression and alcoholism. The high prevalence and significant burden of the disease in terms of patient quality of life emphasise the need for early recognition and effective treatment. However, the condition is under-diagnosed and no treatment guidelines currently exist. Additionally, a number of issues remain to be defined, such as the severity of disease that requires treatment, assessment of treatment response and optimal treatment length. Treatment options include both pharmacological and non-pharmacological therapies; ideally, treatment should also have good long-term tolerability and be effective against common comorbid conditions. The selective serotonin reuptake inhibitors (SSRIs) offer the most promising treatment and several have been investigated in social phobia. Whilst sertraline, fluoxetine, and fluvoxamine have shown promise in small studies or case reports, paroxetine is the only SSRI to have been studied in a large, randomised trial in patients with generalised social phobia, when it was shown to be significantly superior to placebo over 12 weeks. Paroxetine has also demonstrated efficacy in comorbid conditions. Other antidepressants or antianxiety agents have been investigated in social phobia with less success. Selective monoamine oxidase inhibitors have also been evaluated, but the results are either inconclusive (moclobemide) or the compound is no longer available (brofaromine). Benzodiazepines may be effective, but it is not clear whether the efficacy is due to sedation or anxiolysis. Long-term use may lead to dependency and benzodiazepines are contraindicated in patients with alcohol dependence, which limit their use in this patient population. Buspirone and beta blockers are not effective in generalised social phobia. In conclusion, the SSRI paroxetine offers a well tolerated treatment with proven efficacy in social phobia which is also effective in the common comorbid conditions, such as depression.

FC51-5
FAMILY HISTORY, PERSONALITY AND COMORBID SYMPTOMS IN PANIC DISORDER

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Patients receiving a first time diagnosis of panic disorder (PD) were systematically assessed regarding a previously defined set of demographic and clinical variables. Beyond a general descriptive purpose, the study aimed to clarify the relationship between PD and certain personality traits, the occurrence of comorbid psychopathological symptoms and special clinical features related to sleep.

Subjects were diagnosed according to DSM-IV criteria for PD with or without agoraphobia (n = 132) and were medication free. Ages ranged between 18 and 61 years (mean: 32.1 ± 9.9 SD); 54 (40.8%) male and 78 (59%) female; agoraphobia was present in

106 subjects (80.3%); the age of onset was 28.3 ± 7.7 and the duration of the illness was 3 ± 4.2 years. Frequency analyses of the clinical characteristics showed 67 patients (51.1%) had predominant obsessive traits (orderliness, perfectionism and control), either isolated or in association with avoidant and "affective" traits (depressive, hyperthymic or ciclothymic); 34 (25.9%) exhibited isolated avoidant and/or dependent traits. A family history of anxiety and/or depressive disorders occurred in 70 patients (53.4%). Clinically significant symptoms of generalyzed anxiety, depression, obsessive-compulsive and hypochondriac manifestations occurred in 77 (58.3%), 40 (30.3%), 30 (22.7%) and 61 (46.2%) subjects, respectively. Concerning sleep, 81 (61.4%) reported a normal nocturnal sleep and a clear pattern of hypersomnia was detected in 14 (10.6%) patients.

Our demographic data are in line with the results of most epidemiological studies conducted in PD patients. The frequency and type of comorbid symptoms, along with the high representation of avoidant, obsessive and "affective" traits (and the high rates of family history of anxiety and mood disorders) suggest that PD may belong to a "phobic-obsessive" spectrum with close links to affective disease. Sleep "normality" has been described in PD and obsessive-compulsive patients and may constitute a distinctive symptomatic feature of that spectrum of disorders.

FC51-6
COGNITIVE THERAPY OF PANIC DISORDER AND SOCIAL PHOBIA — A FOLLOW-UP STUDY

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Forty-three patients with panic disorder and/or socialphobia (ICD-10 criteria) were included in a treatment programme including 17 group-sessions of cognitive therapy and 17 sessions of relaxation-training and exposure-in-vivo. Pre- and post treatment demographic data, diagnoses and symptomatology were assessed. The same assessment package was applied at a follow-up 1–4 years after end of treatment and ratings of the patients evaluations of the treatment, its effects and failures and their actual application of learning coping-strategies were added.

FC51-7
BEHAVIOR THERAPY AND PHARMACOTHERAPY IN THE TREATMENT OF PANIC DISORDERS AND OBSESSIVE-COMPULSIVE DISORDERS

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Therapy with imipramine and behavioral methods like exposition were regarded as effective methods in patients with panic disorders, whereas exposition and reaction prevention and therapy with clomipramine have proved to be effective in patients with obsessive-compulsive disorders. Although often recommended to combine these methods, there is still a lack of controlled studies in this area.

Pre DSM-III era studies were revieewed, and it will be shown that there were a lot of methodological problems which limits the validity of these studies.

The combined studies of the post DSM-II era - including our own study of the efficacy of a comined therapy with antidepressants an cognitive behavior therapy in the treatment of panic disorders and obsessive-compulsive disorders will be described in detail. By use of a better diagnostic procedure and manuals to conduct therapy these studies reach a higher methodological standard. To sum ist up, there is relatively small empirical evidence that a combination of psychopharmacological and psychotherapeutical methods has an additive effect. Problems like selection of patients, drop-outs, and comorbidity will be discussed.

DEB52. The legalisation of cannabis

Chairs: K Uchtenhagen (CH)

S53. OCD: New frontiers in an old disorder

Chairs: J Zohar (IL), JJ López-Ibor (E)

S53-1
OCD: FROM NEURASTHENIA TO NEUROSCIENCE

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Obsessive compulsive disorder (OCD) has emerged in the last fifteen years as a relatively common condition affecting around 2% of the general population. The shame engendered by the often bizarre symptoms and the chronic nature of OCD mean that the disability caused to the sufferer commonly lasts for many years.

OCD is unique among psychiatric disorders in its specific response to pharmacological interventions. Benzodiazepines, dopamine blockers, non-serotonergic monoamine reuptake blockers, and ECT do not appear to be effective anti-obsessive treatments. To date, only serotonin reuptake blockers were found, in double-blind, placebo-controlled studies, to be effective anti-obsessive medication.

Currently clomipramine, fluoxetine, sertraline, fluvoxamine, paroxetine and cipramil are used in OCD. As all of these medications are also antidepressants, it is important to note that depression is not a prerequisite for their anti-obsessive effects as was demonstrated in studies with non-depressed OCD patients. The specific response of OCD to serotonin reuptake blockers lends support to the serotonergic hypothesis of OCD. Pharmacological challenges with 5HT agonists such as mCPP and sumatriptan provide further support for the role of 5HT in OCD. Current efforts are directed at identifying which 5HT receptor subtype is implicated in OCD.

Modern brain imaging techniques help to reveal the functional anatomy of OCD. From these studies the fronto-basal-ganglia-thalamo-cortical circuit has emerged as an important structure in this disorder. Further studies utilizing brain imaging will help us to correlate relevant changes occurring during pharmacological or behavioral treatment of OCD patients. Although much knowledge has been gained in the last decade, much more remains to be done. The mechanisms of OCD and its treatment need to be further elucidated through integrated clinical, genetic, imaging, neuropsychological, and pharmacological challenge studies.

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