S42-5
TREATMENT ISSUES IN SEXUAL DYSFUNCTION ASSOCIATED WITH PSYCHOPHARMACOLOGICAL AGENTS

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Sexual dysfunction observed with various psychopharmacological agents include changes in libido, impaired erectile capacity, priapism, impotence, painful ejaculation, partial and complete anorgasmia, clitoral engorgement, and neuroendocrine changes. Management of sexual dysfunction associated with antidepressants (which is not studied enough, but is still the most studied area) may serve as a paradigm of sexual dysfunction management associated with other psychopharmacological agents. A baseline assessment of sexual functioning is a crucial part of sexual dysfunction management. Management of dysfunction may include: waiting for spontaneous remission of the dysfunction, reduction to the minimum effective dose of the treatment agent, scheduling sexual activity in relation to time of medication dose, drug holidays, switching to another psychopharmacological agent, or adding various drugs reported to alleviate sexual dysfunction.

All of these approaches have been used with antidepressants. Antidepressants to switch to include a less anticholinergic tricyclic, bupriopion and nefazodone. Various agents which may be added to antidepressants include: bethanechol, cyproheptadine, yohimbine, amantadine, buspirone, bupropion, nefazodone, and psychostimulants. Possible approaches to sexual dysfunction associated with antipsychotics include dose reduction or switching to another agent (loxapine, molindone, haloperidol). Approaches suggested for benzodiazepine induced sexual dysfunction include: dose reduction, switching to another benzodiazepine, switching to buspirone, or using antidepressants for anxiety or insomnia.

Evidence amassed from treatment of sexual dysfunction suggests that dopamine plays an important role in the regulation of sexual desire, serotonin plays an important role of regulation of orgasm (especially stimulation of 5HT2 receptor), and several neurotransmitter systems and receptors may play a role in the regulation of erection.

S43. Measuring subjective quality of life: application of the WHOQOL in clinical and healthy populations

Chairs: M Amir (IL), J Orley (WHO, CH)

S43-1
CONCEPTUAL AND METHODOLOGICAL PRINCIPLES OF THE WHOQOL

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The validity of using a subjective Quality of Life (QOL) measure with psychiatric patients has been questioned. The influence of pathological changes in affective state could mean that a QOL assessment is nothing more than a measure of depression. The low expectations of institutionalized patients could mean that they have an unrealistically high subjective QOL. These and other factors could throw doubt on the value of assessing subjective QOL in psychiatric patients. Taking the perspective of the World Health Organization WHOQOL, the paper examines the conceptual basis of subjective QOL assessment and argues for its validity when used with psychiatric patients. It will, however, stress that such QOL assessment should be only one of several measures used to evaluate a patient's mental state and function, and that no single parameter can truly indicate on its own what the needs of patients might be.

S43-2
THE QUALITY OF LIFE OF PEOPLE LIVING WITH HIV/AIDS

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An additional module to the Geneva WHOQOL (World Health Organization Quality of Life Assessment) has been developed in order to assess specific perceptions and concerns of people living with HIV/AIDS, such as confidentiality, discrimination, early death, sexual activity and other facets. The paper describes the procedures used to develop the module, the results of focus group work and the data from pilot testing in 5 countries of varying cultures and levels of development.

S43-3
WHOQOL-BREF IN THE FIRST DANISH APPLICABLITY STUDIES

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When psychometrically analysing questionnaires, measuring quality of life, we have preferred latent structure analysis compared to factor analysis and Loevinger's coefficient of homogeneity compared to Cronbach's coefficient of internal consistency.

In the first trials with WHOQOL-100 versus WHOQOL-BREF (26 of the 100 items) it was shown that the BREF had highest applicability in schizophrenia. Loevinger's coefficient of homogeneity was acceptable (0.30) in schizophrenia for BREF, but not for WHOQOL-100. When analysing the WHO field (1) data (n = 4104) we obtained a Loevinger coefficient of 0.30. In other woods, the total score of WHOQOL-BREF is a sufficient statistic.

We have transferred the total score of WHOQOL-BREF to an 0–100 scale, in which 100 means the best possible quality of life score. In a pilot study comparing males with diabetes (n = 41) and males with schizophrenia (n = 19) we obtained means scores of 71.5 and 54.6 respectively ($p \leq 0.001$) The results of the Danish population study will be presented.

(1) Harper, A. Power, M. and the WHOQOL group: The WHOQOL user manual. World Health Organization Genevé 1998

S43-4
QUALITY OF LIFE IN CRONIC FATIGUE SYNDROME PATIENTS

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The aim of this paper is to present research on quality of life (QOL) in Chronic Fatigue Syndrome (CFS) patients, using a broad and generic QOL assessment instrument (WHOQOL-100). Quality of life of CFS patients was compared with the QOL of healthy subjects, sarcoidosis, rheumatoid arthritis (RA) and psoriasis patients, a random sample, and a group of elderly persons. Compared with healthy subjects, the CFS patients' QOL appeared to be impaired

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