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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on 'Overall Quality of Life and General Health' and on 22 out of the 24 facets of QOL (e.g., 'Pain and Discomfort', 'Negative Feelings', 'Mobility', 'Activities of Daily Living'). Compared with the other groups, the QOL of the CFS patients appeared to be similar to the QOL of RA patients and substantially lower than the QOL reported by the random sample and the elderly persons, sarcoidosis and psoriasis groups.

S43-5
QUALITY OF LIFE AMONG ISRAELI ARABS AND ISRAELI JEWS

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The WHOQOL-100 is a self-report questionnaire measuring subjective quality of life. The instrument has been developed collaboratively in 15 different academic centers in diverse cultural settings. The instrument has 100 items divided into 6 broad content domains which are further subdivided into 25 facets representing 24 different areas of life and one general facet (general satisfaction with quality of life). The present study was part of the validation of the WHOQOL-100 in Israel. 97 Israeli Jews (Group I) and 95 Israeli Arabs (Group II) matched for age, income, education and gender were administered the WHOQOL-100 in Hebrew and Arabic respectively. Results showed that on the general facet there was no significant difference between the two groups. However regarding the content domains, Group I scored higher than Group II on five of the six domains. The results are discussed in terms of a minority group confronting a continous complex political situation.

FC44. Drug and alcohol abuse

Chairs: K Tómasson (IS), R Vrasti (RO)

FC44-1
MDMA-USERS IN A SPECIALISED ADOLESCENT PSYCHIATRIC OUT-PATIENT SERVICE

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Introduction: The abuse of stimulant and so-called designer drugs has increased dramatically throughout Europe in the last decade. Firstly these drugs such as MDMA ("Ecstasy") were regarded as a fashion, meanwhile they play a central role in addiction behaviour in the age group of 12–25 year old persons and they are not restricted to the rave- and techno-scene anymore.

Project: To assess the need of health care and the psychiatric and somatic problems of regular MDMA-users the Dept. of Child and Adolescent Psychiatry of the Medical University of Lübeck, Germany installed an interdisciplinary out-patient service in January 1997.

Methods: The subjects that required psychiatric service were interviewed according to ICD-10, examined physically and neurologically and underwent (neuro-)psychological testing.

Results: None of the adolescents seeking specific help for MDMA-related problems took the substance alone, most often it was combined with Cannabis, LSD and Amphetamines. As it was expected the number of adolescents that reported drug-related problems in the out-patient dept. increased tenfold. A significant number of patients reported "early" symptoms such as loss of memory, attention deficit and sleep disturbances due to MDMA-intake.

Discussion: In the scientific literature about MDMA there seems to be a gap between clinical reports of severe psychiatric health risks such as psychosis or paranoia and epidemiological evidence of hundreds of thousands of regular users on the continent and the U.K., that seem to have no health problems. This may be an artefact as the typical adolescent MDMA-user does not seek help from regular clinical psychiatric services nor from the drug counselling agencies that focus on alcohol or heroine addicts. Therefore a specific offer to this population seems to be needed and has to be furthermore evaluated.

FC44-2
SOCIODEMOGRAPHIC AND PSYCHOPATHOLOGIC VARIABLES AT THE CHILDREN AND YOUTH WITH THE SUBSTANCE USE

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The goal of the work is recording as the known as still unidentifiable variable psychopathologic phenomens of the developing dependence on the psychoactive substances at the children and young people in Slovakia. We present the computed use of the multifactorial analysis of the psychopathologic phenomens of the 97 pedopsychiatric patients 12–18 years old in the various stages of the children's and young people's life with the dependence on the psychoactive substances.

FC44-3
HOMELESS ALCOHOLICS PREVALENCE OF PSYCHIATRIC COMORBIDITY AND OUTCOME OF DRINKING

K. Tómasson[1] *, P. Vaglum[2]. [1]*University Hospital, Reykjavik, Iceland*
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Objective: To study in a nation-wide treatment seeking sample of alcoholics, the prevalence of having been homeless, its association with psychiatric comorbidity, and course of drinking over the subsequent 28 months.

Methods: A sample of alcoholics and other substance abusers seeking treatment (N = 249 men, 102 women) under medical supervision in Iceland from December 1991 to September 1992 was interviewed with the Diagnostic Interview Schedule, as well as with an alcohol history instrument. Follow-up was conducted at 16 and 28 months.

Results: The prevalence of having been homeless at least once was 25%, there of 11% more than twice. The latter were younger compared with those never homeless (35 vs. 43 years,) had an earlier age at onset (16 vs. 27 years) and had been significantly more often admitted for detoxification. The prevalence of polysubstance abuse was 22% among those who had never been homeless, while it was 48% among those homless at least once, and 71% among those homless more than twice ($p < 0.001$). The prevalence of affective disorders, panic disorder/agoraphobia, other anxiety disorders, and antisocial personality disorder among the homeless were 43%, 56%, 82%, and 52%, respectively compared with 30%, 31%, 55%, and 20% among those who had never lost their home. In the homeless group 10% remained sober through the follow-up period compared with 18% of those never homeless. But none of those homeless more than twice was able to stay sober through the follow-up period.

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