

Response to Balon and Clayton (2014): Female Sexual Interest/Arousal Disorder Is a Diagnosis More on Firm Ground than Thin Air

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With the publication of the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013), there is now an opportunity for wide public reactions to the sexual dysfunctions diagnoses. In their commentary, Balon and Clayton (2014) claimed that the creation of the new DSM-5 diagnosis of Female Sexual Interest/Arousal Disorder (FSIAD) “creates havoc in the entire area of sexual dysfunction.” This is just one of many hyperbolic (and, as we will argue, unsupported) statements made in their commentary. Since it would be impractical to address all of the 13 points that they presented as “unsupporting evidence” for the FSIAD diagnostic category, we focus here on the three primary concerns expressed by Balon and Clayton: (1) the rationale/basis for introducing the new FSIAD diagnostic category; (2) the specific issue of lack of lubrication not being an essential criterion for a FSIAD diagnosis; and (3) the likely consequences of the new diagnosis.

Rationale/Basis for FSIAD

Balon and Clayton focused much of their commentary on what they regard as an insufficient rationale for deleting the DSM-

IV-TR (American Psychiatric Association, 2000) Female Sexual Arousal Disorder (FSAD) diagnosis and for introducing FSIAD. They suggested that the primary reasons for the changes were “to dismantle the long-standing linear concept of the sexual response cycle” and “to replace it with another concept of sexual response (circular model).” Both assumptions in this statement are incorrect. First, the desire to move beyond the widely-criticized human sexual response cycle (HSRC) model as a framework for female sexual disorders was one of only many reasons put forward for our DSM-5 proposals. Our DSM-5 Workgroup was certainly not the first to express dissatisfaction with the HSRC; in fact, there has been longstanding discontent with the application of this single model of sexual response to both women *and* men. Second, Balon and Clayton are incorrect in their assertion that the “circular model” proposed by Basson (2000) has replaced the HSRC model as a framework for the classification of female sexual disorders. It most certainly has not, as this would pigeonhole women into a single model of sexual response that may not fit all women. In fact, our Workgroup felt strongly that the diagnosis incorporate a polythetic structure so that women who experience and express their sexual response in different ways might be captured. This was not based on “opinion,” as Balon and Clayton suggested, but on evidence that only a third of women identify with the HSRC (Sand & Fisher, 2007).

Balon and Clayton are correct that the guidelines provided by the American Psychiatric Association (APA) for Workgroup proposals for changes to DSM diagnoses were that the definitions/criteria have clinical utility, that continuity with DSM-IV criteria be maintained (where possible), and that recommendations for change be based on scientific evidence. These were priorities that our Workgroup studied and discussed thoroughly over the course of five years and that we took extremely seriously. Balon and Clayton’s claim that the creation of FSIAD was based on “ideology and personal beliefs, rather than on published

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scientific and clinical evidence” is groundless and disrespectful. Our Workgroup published extensive literature reviews on each of the DSM-IV female sexual disorders (see Binik, 2010a, 2010b; Brotto, 2010; Graham, 2010a, 2010b) and also produced a detailed “Memo Outlining Evidence of Change” (MOEC) for the proposed FSIAD category which underwent various levels of scrutiny at APA.

It is therefore puzzling how Balon and Clayton were unable to “find a single published article to support the separation of the genders in regard to desire and arousal.” Our literature reviews provided references to many studies reporting gender differences in sexual response and there is now widespread recognition of the importance of conceptualizing women’s sexual problems differently from those of men (Bancroft, Loftus, & Long, 2003). We were also confused about Balon and Clayton’s division of “scientific evidence” into “real/published” data and “theoretical data,” with the implication being that “theoretical data” are somehow less convincing. In our view, most of the high-quality research informing our understanding of women’s sexual response has been theory-based (e.g., the extensive and elegant program of research carried out by Everaerd, Both, Laan, and other Dutch colleagues using the incentive motivation model).

Balon and Clayton commented that there “is no broad consensus of expert clinical opinion, either in psychiatry or in sexual medicine supporting the establishment of this [FSIAD] diagnosis.” The DSM process involved several opportunities for feedback from clinical and research colleagues as well as the public (through the DSM-5 website, at scientific meetings, and from expert advisors) and our Workgroup spent hours reading and discussing every piece of feedback. However, unlike earlier attempts to modify definitions and criteria for sexual disorders based on expert “consensus conferences” (Basson et al., 2000; Kloner, 1993; Lewis et al., 2004), the goal of the DSM-5 revision process was not to reach “expert consensus.” We did, however, incorporate feedback and suggestions from clinicians, researchers, and the public as well as from the APA Task Force and the Scientific Review Committee in revising our draft proposals.

Balon and Clayton highlighted the fact that a diagnosis of FSIAD requires that a woman meet three of six diagnostic criteria and commented that “a woman could be diagnosed as suffering from Female Sexual Interest/Arousal Disorder without any impairment of arousal.” They argued that this “does not make any logical sense” but this criticism reveals a fundamental lack of understanding of how FSIAD was conceptualized, as articulated in published reviews (Brotto, 2010; Graham, 2010a). Our Workgroup concluded that there should be no distinction between sexual interest and arousal (hence the “/” in “Sexual Interest/Arousal Disorder”); as Laan and Both (2008) stated, “There is no good reason to assume that feelings of desire and arousal are two fundamentally different things” (p. 510). There is also evidence from empirical studies that, when asked directly, women often conflate sexual interest and arousal and have

trouble distinguishing them in their experiences (Beck, Bozman, & Qualtrough, 1991; Brotto, Heiman, & Tolman, 2009; Graham, Sanders, Milhausen, & McBride, 2004).

Finally, Balon and Clayton are correct that there were no APA field trials testing the proposed diagnostic criteria for FSIAD. Our Workgroup submitted proposals to APA for funding field trials on the proposals for disorders that were either new or substantially revised. Unfortunately, the sexual disorders were considered lower priority compared to other mental disorders, such as depression and schizophrenia, which were the focus of field trials, and no funding was provided for any field trials of sexual disorders. Despite the lack of field trials, other researchers have attempted to examine the overlap of FSIAD with DSM-IV-TR diagnoses of HSDD and FSAD. As Balon and Clayton are aware, using FSIAD’s required three diagnostic indicators (out of six) led to most women who were diagnosed with HSDD also meeting criteria for FSIAD (Derogatis, Clayton, Rosen, Sand, & Pyke, 2011). Personal communication from industry researchers who are testing DSM-IV-TR versus DSM-5 criteria in women participating in clinical trials suggests that there is strong agreement between the two diagnoses (R. T. Segraves, personal communication, October 24, 2013). Of course, we agree with the need for research on the reliability and validity of the SIAD criteria, but we are confident that the revised definitions of female sexual disorders are an improvement over DSM-IV and better reflect the actual clinical reality of women’s experiences of sexual problems.

Lack of Lubrication No Longer Being an Essential Criterion for a Diagnosis

Balon and Clayton criticized the fact that the FSIAD diagnostic criteria do not mention lack of lubrication. The primary reason that the DSM-IV category of FSAD was deleted was that the diagnosis was made solely on the basis of impairment of “an adequate lubrication-swelling response” with no reference to subjective arousal, despite the fact that women rarely present with the sole symptom of genital swelling insufficiency or a lack of lubrication (Graham, 2010a). Instead, complaints of insufficient lubrication/dryness are often referred to a specialist gynecologist and diagnosed as vulvar-vaginal atrophy—and not as a sexual dysfunction. Either a non-hormonal moisturizer or a topical estrogen usually remedies these symptoms (Bachmann & Leblum, 2004). One of the six indicators of Criterion A (“lack of, or significantly reduced, sexual interest/arousal”) for FSIAD is “absent/reduced genital sensations during sexual activity” and the accompanying text includes the statement that “this may include reduced vaginal lubrication/vasocongestion” (American Psychiatric Association, 2013, p. 511). Thus, reduced vaginal lubrication may be one of the presenting symptoms for a woman receiving a diagnosis of FSIAD, but it is neither a necessary nor a sufficient one; this reflects the research that

demonstrates measures of genital response do not differentiate women who report sexual arousal problems from those who do not (Laan, van Driel, & van Lunsen, 2008).

Balon and Clayton made a number of other inaccurate and misleading statements about the FSIAD criteria. For example, they suggested that the mention of “genital or nongenital sensations” under Criterion A “fails to indicate these should be sexual in nature.” In fact, the actual wording of this criterion is “absent/reduced genital or nongenital sensations *during sexual activity*” (American Psychiatric Association, 2013, p. 433) (our emphasis). They also asserted that evidence supporting the inclusion of genital or nongenital sensations was not presented and that the meaning of the term “nongenital sensation” was never defined. Again, both of these statements are inaccurate: both the literature review of FSAD (Graham, 2010a) and our APA MOEC for FSIAD referenced research and clinical data supporting inclusion of these indicators (including reference to Masters and Johnson’s original research, which demonstrated “extragenital” physiological changes occurred during sexual arousal, something that DSM-IV criteria for FSAD did not incorporate).

We do not understand the basis for Balon and Clayton’s suggestion that “clinicians may be less inclined to recommend the use of lubricants for women diagnosed with FSIAD.” Sensate focus exercises are often recommended for couples with sexual desire/arousal concerns despite “inadequate touch” not being part of the diagnostic criteria. Because symptoms of reduced genital lubrication/vasocongestion are often completely relieved with the use of personal lubricants and moisturizers (Bachmann & Leiblum, 2004), we see no reason to expect that clinicians’ recommendations for lubricant use to improve symptoms of vaginal dryness will change because of the FSIAD criteria.

Balon and Clayton also maintained that genetic evidence supporting FSIAD is lacking and that some genetic data might argue against the FSIAD diagnosis, citing a study by Burri, Greven, Leupin, Spector, and Rahman (2012) in support of this. The main conclusions reached by Burri et al., however, were that female sexual dysfunction should be viewed as “multidimensional from clinical, phenotypic, and etiological perspectives” (p. 10) and that diagnostic subtypes of female sexual disorders organized by etiology should be considered. We would contend that the polythetic criteria of FSIAD are consistent with a multidimensional perspective and, while we agree that a classification system based on etiology should be considered, we do not think that at present the requisite research base needed for this is available.

Lastly, Balon and Clayton questioned the use of “psychological measures that may be...unreliable and vary between clinicians” instead of “physiological changes measured with current available tools.” However, given that to date there are no unequivocal blood tests, examinations, or other “objective” measures of sexual dysfunction, we are unsure what they are

suggesting should replace the use of self-report measures of sexual arousal/interest difficulties.

Likely Consequences of the DSM-5 Changes to the Classification of Female Sexual Disorders

Some of the strongest statements made in Balon and Clayton’s commentary pertain to the potential for the FSIAD diagnosis to “inflict harm” and to “create havoc.” Specifically, they suggested that women who met DSM-IV criteria for HSDD or FSAD may be “excluded” from a DSM-5 diagnosis of FSIAD. Interestingly, they also commented, “Contrary to the possible intentions of the creators of this diagnosis, the influence of the pharmaceutical industry in the treatment of female sexual dysfunction may increase due to the existence of this fuzzy, all-encompassing diagnosis.” To clarify, our Workgroup’s goals in formulating proposals for DSM-5 did not include any attempt to modify (either increase or decrease) the influence of the pharmaceutical industry. As we have stated previously (Brotto, Graham, Binik, & Segraves, 2011), our Workgroup felt it was important to “raise the bar” for what qualifies as a disorder, given the extremely high rates of female sexual dysfunction reported in some epidemiological studies (Laumann, Paik, & Rosen, 1999). This concern about over-diagnosis has been echoed by many other researchers and clinicians. Regarding the description of the FSIAD diagnosis as “fuzzy” and “all-encompassing,” we are at a loss to understand what Balon and Clayton mean by this. In fact, the inclusion of explicit severity and duration criteria in DSM-5 and the detailed polythetic criteria for FSIAD contrast sharply with the previous DSM-IV criteria which, for example, included no definition of “persistent” or “recurrent” symptoms. Feedback we received from publicized drafts of the FSIAD criteria on www.dsm5.org indicated that the inclusion of these objective duration and severity markers were seen as major improvements from previous vague criteria found in DSM-IV-TR.

In conclusion, we would argue that many of Balon and Clayton’s emotive concerns about the FSIAD diagnosis are unfounded (and insulting to the credibility and five year efforts of the Sexual Dysfunctions workgroup). Although they do not make this explicit, they seem particularly concerned about the lack of continuity with DSM-IV (e.g., “and mainly...FSIAD clearly does not offer any cogent diagnostic continuity...from DSM-IV.”). Yet, nowhere in their commentary was there any acknowledgment that the previous DSM-IV criteria were widely regarded as unsatisfactory, both from clinical and research perspectives (Bancroft et al., 2003; Basson et al., 2000). Although the reliability and validity of the FSIAD criteria still need to be established, we believe that the DSM-5 FSIAD diagnosis is an important move away from outmoded and unidimensional views of the nature of the sexual response (Binik, Brotto,

Graham, & Segraves, 2010) and will facilitate the acquisition of new and more clinically relevant research data.

Acknowledgments Graham and Brotto were members of the DSM-5 Sexual Dysfunctions subworkgroup, which was part of the Sexual and Gender Identity Disorders Workgroup. Zucker was the Chair of the Sexual and Gender Identity Disorders Workgroup.

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