Study Supports Subtypes of Female Sexual Arousal Disorder

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SANTA FE, N.M. — Although the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders defines only one type of female sexual arousal disorder, there is now physiologic evidence that there are at least two subtypes of the disorder, Lori A. Brotto, Ph.D., reported at the annual meeting of the Society for Psychophysiologic Research.

For a diagnosis of female sexual arousal disorder (FSAD), DSM-IV-TR requires "persistent or recurrent inability to attain an adequate lubrication-swelling response of sexual excitement." Although some women with FSAD do complain chiefly of genital impairment, others report that while their body becomes aroused, they don’t become aroused psychologically.

In a study involving 70 women, Dr. Brotto of the University of Washington in Seattle examined 8 women reporting the genital subtype of FSAD, 26 reporting the subjective subtype, and 36 control subjects reporting no difficulties in becoming aroused. All women watched neutral and erotic films while their vaginal pulse amplitude—a reliable measure of genital arousal—was measured by a vaginal photoplethysmograph. The women provided a continuous measure of their subjective responses by changing the position of a lever. The women underwent testing on two occasions, once after laborator-induced hyperpnea, which activates the sympathetic nervous system, increased the change in vaginal pulse amplitude between neutral and erotic films.

In both the control women and those with FSAD, the erotic film resulted in significant increases in vaginal pulse amplitude. All women responded to the erotic film with perceived autonomic arousal and perceived physical arousal, but women with FSAD reported less overall. Overall, women in the control group reported more positive effects than did women with FSAD.

The vaginal photoplethysmography supported the reports of women who complained of problems with genital arousal. These women showed no significant increase in vaginal pulse amplitude in response to the erotic films. Women who complained of a subjective arousal disorder, on the other hand, did show evidence of significant genital arousal.

Although the control women and the women with the genital arousal subtype of FSAD showed a potentiated physiologic response to the erotic film after hyperventilation, women with the subjective subtype of FSAD showed a significantly smaller physiologic response after hyperventilation than before.

Hyperventilation resulted in no significant changes in the subjective measures in either the control or the FSAD women. This finding suggests that the effect of this manipulation occurred exclusively at a physiologic level and was not due to distraction or other psychological causes.

One implication of the study is that women with the subjective subtype of FSAD may have differences in basal sympathetic tone, compared with women with the genital subtype or women without FSAD. Another implication is that vaginal photoplethysmography, now exclusively a laboratory technique, may find a place as a diagnostic tool used to differentiate between FSAD subtypes.

Stopping Hormonal Contraceptives May Reverse Sexual Dysfunction

PHILADELPHIA — Discontinuation of hormonal contraceptives should be the first-line approach in addressing sexual dysfunction in women using these agents.

Susan Sarajari, M.D., outlined her study of 20 women who experienced improved sexual function and testosterone levels after discontinuing hormonal contraceptives that are promoted by drug companies and norgestimate or a ring (ethinyl estradiol and norgestimate). The study was supported by a grant from Organon Pharmaceuticals Inc., maker of the NuvaRing vaginal ring.

On average, the women gained 2.8 pounds, regardless of baseline weight or BMI and type of contraceptive used. The 14 women who reported a “bad change” in weight at the study’s end had gained an average of 4.4 pounds, while the 112 women who reported “no change” had gained 2.2 pounds, and the 14 women who reported a “good change” had gained 3.3 pounds.

The mean weight of all the women studied was 146 pounds, and included women with BMIs in the healthy (less than 25), overweight (from 25 to 30), and obese (greater than 30) range.

In a second poster, Dr. Katharine O’Connell and Dr. Carolyn Westhoff of Columbia University reviewed data from 130 observational studies of combined hormonal contraception and weight gain dating from 1966 to 2003. These studies excluded premenopausal and postmenopausal women, found only a correlation, and most (118 of 136) included an oral contraceptive.

Regardless of what type of contraceptive was used, the investigators concluded that all weight gains described during hormonal contraception use were not significantly different from weight changes in the general United States population over the same period.