

DSM-5 Changes in Diagnostic Criteria of Sexual Dysfunctions

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Introduction

The Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria proved to be in a constant of evolution [1]. The first edition of the DSM, in 1952, catalogued 60 categories of abnormal behavior. By 1994, the fourth edition (DSM-IV) listed 297 separate disorders and over 400 specific psychiatric diagnoses [2]. As with other disorders, DSM criteria for sexual dysfunctions reflect the prevailing psychiatric thinking of the time of publication; they have thus evolved throughout the years, reflecting advancements in the understanding of sexual disorders. For instance, in the first edition of the DSM, in 1952, impotence and “frigidity” were listed under “**psychophysiological autonomic and visceral disorders**” [3]. Likewise, diagnostic categories of female sexual interest as described in the DSM IV 1994 [4] were based on the model of human sexual response proposed by Masters and Johnson [5], and further developed by Kaplan [6]. However, recent research has put into question the validity of that model; both the strict distinction between different phases of arousal and the linear model of sexual response were found to inadequately explain sexual behavior, particularly in women [7-9]. This has in turn led to several proposed changes in sexual dysfunction diagnostic criteria [1,10].

The DSM-5, published in May of 2013, seeks to incorporate some of aforementioned findings [11]. Changes were made in the sexual dysfunctions chapter in an attempt to correct, expand and clarify the different diagnoses and their respective criteria. Although many of the changes are subtle, some are noteworthy: gender-specific sexual dysfunctions were added, and female disorders of desire and arousal were amalgamated into a single diagnosis called “**female sexual interest/arousal disorder**”. Many of the diagnostic criteria were updated for increased precision: for instance, almost all DSM-5 sexual dysfunction diagnoses now require a minimum duration of 6 months as well as a frequency of 75%-100% [11].

The purpose of this article is to present and explain the changes that were introduced to the nomenclature and diagnostic criteria of sexual dysfunctions in the DSM-5.

Revised Classification

The classification of sexual dysfunctions was simplified. There are now only three female dysfunctions and four male dysfunctions, as opposed to five and six, respectively, in the DSM-IV. Female hypoactive desire dysfunction and female arousal dysfunction were merged into a single syndrome called **sexual interest/arousal disorder**. Similarly, the formerly separate dyspareunia and vaginismus are now called genito-pelvic pain/penetration disorder. **Female orgasmic disorder** remains in place.

As for males, **male hypoactive sexual desire disorder** now has a separate entry. Male orgasmic disorder was changed to **delayed ejaculation**, the “male” adjective was dropped from **erectile disorder**, and **premature ejaculation** remains unchanged. Male dyspareunia or male sexual pain does not appear in the sexual dysfunctions chapter of the DSM-5.

Additionally, sexual aversion disorder and sexual dysfunction due to a general medical condition are absent from the new edition. The Not Otherwise Specified (NOS) category was scrapped from the sexual dysfunctions chapter as well as elsewhere in the DSM-5. Finally, substance- or medication-induced sexual dysfunction remains unchanged. The DSM-IV and DSM-5 classifications are compared in Table 1.

Revised Diagnostic Criteria Applicable to All Diagnoses

Unlike its predecessor, the DSM-5 includes the requirement

DSM-IV-TR Diagnoses	Changes in DSM-5
<i>Female dysfunctions</i>	
Female hypoactive desire disorder	Merged into: Female sexual interest/arousal disorder
Female arousal disorder	Merged into: Female sexual interest/arousal disorder
Female orgasmic disorder	Unchanged
Dyspareunia	Merged into: Genito-pelvic pain/penetration disorder
Vaginismus	Merged into: Genito-pelvic pain/penetration disorder
<i>Male dysfunctions</i>	
Male erectile disorder	Changed to Erectile disorder
Hypoactive sexual desire disorder	Changed to Male hypoactive sexual desire disorder
Premature (early) ejaculation	Unchanged
Male orgasmic disorder	Changed to Delayed ejaculation
Male dyspareunia	Not Listed
Male sexual Pain	Not Listed
<i>Other dysfunctions</i>	
Sexual aversion disorder	Deleted
Sexual dysfunction due to a general medical condition	Deleted
Substance/medication-induced sexual dysfunction	Unchanged
Sexual dysfunction NOS	Replaced by Other specified sexual dysfunctions and Unspecified sexual dysfunction

Note: Individual changes to DSM nomenclature and criteria are in bold.

DSM: Diagnostic and Statistical Manual of Mental Disorders; IV-TR: 4th Edition-Text Revision; NOS: Not Otherwise Specified

Table 1: Sexual dysfunctions in DSM-5: Changes in classification from DSM-IV.

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of experiencing the disorder **75%-100% of the time** to make any diagnosis of sexual disorder, with the notable exception of substance- or medication-induced disorders. Moreover, there is now a required minimum duration of approximately **6 months**. Finally, in order to make a diagnosis, the disorder must be deemed to have caused **significant distress** (the DSM-IV requirement of “interpersonal difficulty” was removed).

One new exclusion criterion was added: the disorder should not be better explained by a “**nonsexual mental disorder, a consequence of severe relationship distress (e.g., partner violence) or other significant stressors**”. In addition to the existing specifiers of lifelong versus acquired disorder and generalized versus situational, a new severity scale was added: the disorder can be described as mild, moderate or severe. The subtypes indicating etiological factors (due to psychological or combined factors) were dropped.

A new group of criteria called “**associated features**” was also introduced. It is subdivided into five categories: 1) partner factors (e.g., partner sexual problem; partner health status); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., poor body image; history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression; anxiety), or stressors (e.g., job loss; bereavement); 4) cultural or religious factors (e.g., inhibitions related to prohibitions against sexual activity or pleasure; attitudes toward sexuality); and finally 5) medical factors relevant to prognosis, course, or treatment.

Revised Diagnostic Criteria of Individual Dysfunctions

Diagnosis-specific criteria- or criteria “A” -were in most cases amended or expanded. In addition to the abovementioned duration and frequency requirements, the most important innovation is the introduction of criteria checklists, which already existed elsewhere in the DSM. A patient now needs fulfill a certain number of “A” criteria- e.g. one out of three- in order to qualify for the diagnosis.

The criteria of the newly-introduced female disorder of sexual interest/arousal are based on those of hypoactive desire disorder. In addition to absent or decreased sexual interest, and erotic thoughts or fantasies, there are four new criteria taking into account absent or decreased activity in four additional aspects of sex life: initiation of sexual activity or responsiveness to a partner’s attempts to initiate it, excitement and pleasure, response to sexual cues, and sensations during sexual activity, whether genital or non-genital. Three out of six criteria are required for diagnosis.

As for the diagnosis of female orgasmic disorder, one or both of the following should be present 75%-100% of the time: absence, infrequency or delay of orgasm, and/or reduced intensity of said orgasm. Regarding the new genito-pelvic pain/penetration disorder, one of the following should occur persistently or recurrently to establish a diagnosis: difficulty in vaginal penetration, marked vulvovaginal or pelvic pain during penetration or attempt at penetration, fear or anxiety about pain in anticipation of, during, or after penetration, and tightening or tensing of pelvic floor muscles during attempted penetration.

Changes to criteria for male sexual dysfunctions are more limited in scope. The requirements for male hypoactive desire disorder are exactly the same as those for undifferentiated hypoactive desire disorder in the DSM-IV. Likewise, the criteria for erectile disorder are similar to the ones in the previous edition, with the notable addition of the 75%-100% requirement as well as the symptom of decreased erectile rigidity. The entry for delayed ejaculation-formerly male orgasmic disorder-remains essentially the same, as does that for premature ejaculation, except for

an added time constraint: ejaculation must occur within approximately one minute following vaginal penetration. It should be noted that while the diagnosis of premature ejaculation diagnosis is applicable in the context of nonvaginal intercourse, there is no specific duration requirement in that case.

Finally, the diagnosis of sexual dysfunction due to a general medical is absent from the DSM-5, and the criteria for substance/medication-induced sexual dysfunction are unchanged and include neither the 75%-100% nor the 6 months requirements.

Discussion

The DSM-5 seeks to remedy some of the inconsistencies of the previous edition. Arguably, one of the major changes that the DSM-5 introduces to the classification of sexual dysfunctions is the merger of sexual disorders of desire and arousal in females. Researchers who advocated this amalgamation [12] based their recommendations on a large body of research suggesting that the separation may have been artificial. In addition to the increased rejection of a linear model of sexual arousal [8,9], a high comorbidity of disorders of desire and arousal was demonstrated in both men and women [13,14]. However, the response to this alteration was not unanimously positive. Sarin et al. disputed the aforementioned claims and argued that the new criteria excluded an excessively large number of low desire and arousal patients [15]. Clayton et al. further argued that the combination of the two diagnoses was counterproductive because patients with hypoactive sexual disorder often presented with incomplete loss of receptivity and were therefore likely to be excluded using the new criteria [16]. Moreover, they contended that most women with sexual arousal disorder met none of the proposed “A” criteria for female sexual interest/arousal disorder and would also be left out [17].

Another important change was the fusion of the diagnoses of dyspareunia and vaginismus into a single entry named genito-pelvic pain/penetration disorder. This decision was based on the conclusion that the two disorders could not be reliably differentiated, for two main reasons. Firstly, the diagnostic formulation of vaginismus as “vaginal muscle spasm” was not supported by empirical evidence [18]. Secondly, fear of pain or fear of penetration is commonplace in clinical descriptions of vaginismus [18]. Kaplan even describes it as «phobic avoidance» [6]. Carvalho et al., after testing five alternative models of female sexual function, concluded that the diagnoses vaginismus and dyspareunia overlapped to a great degree [19]. One consequence of the collapse of the two diagnoses is male dyspareunia which, because it was deemed exceedingly rare, was scrapped completely from the nomenclature [20].

The diagnosis of sexual aversion disorder was similarly deleted from the DSM. The rationale behind this decision was that the diagnosis had very little empirical support. Furthermore, it was noted that sexual aversion shared a number of similarities with phobias and other anxiety disorders and therefore did not belong in the sexual dysfunctions chapter of the DSM-5 [21].

The new edition introduced duration and frequency requirements for sexual disorders. All diagnoses except substance- and medication-induced sexual dysfunction now require a minimum duration of approximately 6 months as well as the presence of symptoms 75%-100% of the time. This development corrects what was seen as a flaw in sexual dysfunction diagnostic criteria, especially when compared to other DSM-IV diagnoses which did have duration requirements [1].

Conclusion

The changes introduced by the DSM-5 to the nosology of sexual dysfunctions aims at increasing its validity and clinical usefulness. Although some of the innovations were criticized by some members of the psychiatric community, it could be argued that, to a certain extent, the fifth edition was successful in reflecting the current state of research in the field sexual disorders.

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