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Critiques and Challenges to Old and Recently Proposed American Psychiatric Association's Website DSM 5 Diagnostic Criteria for Sexual Dysfunctions

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ÖZET:

Cinsel işlev bozuklukları tanı ölçütlerinin eski ve Amerikan Psikiyatri Derneği internet sitesinde sunulan yeni biçimiyle gözden geçirilmesi ve eleştirisi

Cinsel işlev bozuklukları (CİB)'nın bugüne kadar yapılmış sınıflandırma ölçütleri yeterli klinik ve epidemiyolojik araştırma verilerleri ile desteklenememiştir. Tanı ölçütleri DSM 5' e kadar daha çok uzman görüşü üzerine temellenmiş, ampirik çalışmalardan gelen kanıtlarla yeterince desteklenmemiştir. Ayrıca CİB'in daha önceki tanı ölçütlerinde "kısa sürede, çok kısa sürede, tekrarlayıcı, inatçı" gibi netlik ve özgüllük içermeyen ifadeler kullanmıştır. DSM 5'in APA internet sitesinde önerilen tanı ölçütleri bu belirsiz ifadelerden uzak durmaya çalışmış ve daha ölçülebilir ve somut tanımlamalar getirmeye gayret etmiştir. APA internet sitesinde önerilen DSM 5 tanı ölçütleri, "homojen" gruplar belirlemek ve bu homojenite içine girmeyen kişileri "bozukluk" kapsamında değerlendirmemek amacıyla tanımlamada özgül süre ve şiddet ölçütleri kullanmıştır.

Şu ana kadar yapılmış tüm DSM sınıflandırma sistemlerinde kadın ve erkek cinselliğinin aynı çizgisel (lineer) cinsel yanıt döngüsünden geçtiği varsayılmış ve sınıflandırma bu çizgisel döngü üzerinden yapılmıştır. DSM 5 önemli bir kavram değişikliği yaparak farklı cinsiyetlerin cinsel yanıtlarının mutlaka benzer olmayabileceğini vurgulamış ve böylelikle CİB'in tanısal sistemine yeni bir boyut getirmiştir. Ayrıca kadın cinsel istek bozukluğu ile kadın cinsel uyarılma bozukluğu tanılarını birleştirmiş ve "kadın cinsel istek ve uyarılma bozukluğu" biçiminde tek bir kategori içinde tanımlamıştır.

Bu makalenin amacı DSM IV TR ile APA'nın internet sitesinde yayınlanan DSM 5 ölçütlerini hem karşılaştırmak hem de kıyaslamak yanısıra DSM 5 için önerilen değişiklikler konusundaki temel mantığı aktarmak olmuştur. Makale ayrıca DSM 5 için önerilen ölçütleri tartışmakta ve gelecekteki sınıflandırmada göz önünde bulundurulması gereken noktalara vurgu yapmaktadır.

Anahtar sözcükler: Cinsel işlev bozuklukları, tanı ölçütleri, operasyonel ölçütler, eleştiri ve gözden geçirme, DSM 5

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ABSTRACT:

Critiques and challenges to old and recently proposed American Psychiatric Association's website DSM 5 diagnostic criteria for sexual dysfunctions

All the DSM classifications until present time based definitions of sexual dysfunctions on expert opinions that were not supported by sufficient clinical or epidemiological data. Additionally, older definitions of sexual dysfunctions (SD) included vague terms such as satisfactory, soon after, rapid, short, minimal, recurrent and persistent which were not precise and difficult to interpret. The DSM 5 attempted to operationalize the diagnostic criteria and avoided these vague terms. It also used specific duration and severity criteria to identify more homogeneous groups for purposes of good clinical epidemiological research and better treatment decisions. All of the DSM classifications until DSM 5 classified male and female SD on the same continuum based on unified sexual response cycles. DSM 5 made a major conceptual change and emphasized that different genders' sexual disorders are no longer required to be analogous. DSM 5 also merged female desire and arousal diagnosis into one entity defined as female sexual interest and arousal disorders. This paper aims to compare and contrast proposed APA website DSM 5 definitions of SD with that of DSM IV TR and explains the rationale for making these changes. It subsequently challenges the suggested DSM 5 criteria and addresses some issues to be considered further for future diagnostic criteria.

Key words: Sexual dysfunction, diagnostic criteria, operational criteria, critiques and challenges, DSM 5

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INTRODUCTION

A considerable amount of available information regarding definition of sexual dysfunctions (SD) have been challenged during the last few years.

What makes a sexual problem become a dysfunction?

One of the basic challenges is about defining what makes a sexual problem become a dysfunction or disorder. Conditions such as delayed ejaculation, vaginismus or erectile dysfunction (ED) may be symptoms of other medical diseases such as diabetes mellitus. They may also be variations of ordinary sexual responses which represent transient alterations in normal sexual activities. They may emerge as consequences of relationship problems and/or in response to the sexual problems of the presenting partner for adaptive purposes. Therefore more precise definitions should be made to differentiate disorders from other transient conditions.

Why more precise definitions?

This lack of consensus in defining SD leads to problems in determining their prevalence. Prevalence rates and epidemiological data are important for assessment of overall impact of a clinical condition in a given society. Standardized operational criteria and reliable measures are therefore needed to improve our knowledge on prevalence rates of different SD. This may be crucial in determining priorities in health policies and in conducting reliable epidemiological and clinical research.

All the DSM classifications until present time based definitions of SD on expert opinions that were not supported by sufficient clinical or epidemiological data. Additionally, definitions included vague terms such as "satisfactory, rapid, short, minimal, recurrent, persistent, etc." that were not possible to be quantified (1,2). It is argued that diagnostic criteria of many SD are so imprecise that they hamper advancements in the field of sexual medicine (3).

Therefore, a search for making better definitions emerged as a necessity for scientific evolution. Efforts were made to base definitions on research data and to establish more precise operational criteria sets in DSM 5. One concrete result of such efforts was acceptance of "one minute duration from penetration to ejaculation" as a necessary construct to diagnose premature ejaculation (PE) (1,2,4).

Do male and female sexual responses follow the same pattern?

Another very important challenge comes from increasing recognition that male and female sexuality could be quite different (5). Until DSM 5 different genders' sexual responses were assumed to be analogous. The DSM IV TR, published by the American Psychiatric Association (6), classified male and female SD on the same continuum based on unified sexual response cycles. It assumed a linear cycle for both of the genders that consisted of successive stages such as desire, arousal and orgasm. This kind of classification was criticized for not taking into account the complexity of sexual experiences that are unique for each single person and especially for different genders. There is considerable data (5,7,8) today to claim that sexual interest, motivation, arousal and pleasure may be experienced differently in different genders.

Therefore, definitions based on common sexual response cycles are nowadays challenged leading to a major paradigm shift suggesting that male and female sexuality are different and therefore subject to be classified and managed differently (9).

Why more precise duration and severity criteria? – Changes in A and B criteria of SD

Although the A category of DSM focuses on defining sexual disorders per se, previous versions of DSM for SD did not specify precise severity and duration criteria of diagnostic symptoms. Establishing specific criteria related to the duration

and severity of the condition is today seen as another necessity to make better definitions and to distinguish SD from variations of normal sexual functions, from transient sexual problems and from sexual difficulties related to life events and relationship problems (10). Therefore the proposed APA website DSM 5 criteria included specific durations and suggested using severity measures. Epidemiological research indicates that criteria specifying duration of more than 6 months, combined with a criterion of quite often (occurring in more than at least 75% of sexual encounters) serves to distinguish sexual dysfunctions from sexual difficulties and transient problems (3). In other words, a duration of ≥ 6 months eliminated most of the sexual difficulties related to transient situational variables and criteria of "quite often" that match the DSM requirement of problem being recurrent or persistent was defined operationally as occurring on ≥ 75% of sexual encounters. No doubt, one could still argue the validity of such definitive numbers for making diagnosis but establishing more precise definitions is a necessity for advancement and scientific evolution in the field of sexual medicine. The clinicians and researchers are preferably expected to agree on operational diagnostic criteria based on evidence rather than clinical observations in order to make sure that they are investigating and treating the same disorder when comparing the efficacy of two different interventions (3,11,12).

The B category of the DSM-IV TR (6) definitions for SD added "marked distress and interpersonal difficulty" dimension to all dysfunctions. One challenge is on including terms such as "interpersonal difficulties" or "partner distress" in the definition as B criteria in order to fulfill SD criteria. Although most of the time a sexual activity involves two partners (at least), many clinicians today tend to avoid labeling people on the basis of their partner's distress while they are not themselves uncomfortable. Additionally some individuals who have SD do not have partners. The proposed APA website DSM 5 criteria suggests to rephrase marked distress as "clinically significant distress or impairment". It seems to delete "interpersonal difficulty" dimension. Further debates are expected to continue in future to conclude whether a complaint should be considered as a disorder only when it causes personal distress or both interpersonal difficulty and clinically significant distress.

This paper aims to compare and contrast proposed APA website DSM 5 definitions of SD with that of DSM IV TR. The final version of DSM 5 has not yet released and therefore writing this paper before the final version becomes available seemed timely and hopefully interesting for the reader. It may be possible that some of the critiques may not apply to the final version of DSM 5 but we thought it is important to challenge the proposed version as that is the only available version. We also thought it might be thought provoking to write such a paper hoping that it will facilitate and encourage other authors to think, discuss, debate and challenge the new and old diagnostic criteria of SD as soon as the new DSM 5 appears.

A comparison of DSM IV TR and proposed DSM 5 Classifications for sexual disorders

All of the DSM IV TR diagnostic criteria had A and B categories. The A category focused on defining sexual disorder per se whereas the B category added a "marked distress or interpersonal difficulty" dimension to the definition of all dysfunctions. These categories aimed to differentiate a dysfunction from its emotional impact both at intra and interpersonal level (13). The common wording selected to emphasize the significance of frequency in the A criterion for all dysfunctions were "persistent or recurrent". DSM IV TR called attention to 3 different dimensions for each sexual disorder and suggested clinicians to specify the type of the disorder as; a) lifelong-acquired b) generalized-situational c) due to psychological or combined factors.

The A category that defined the disorder in DSM 5 reflected current clinical and research findings. More precise definitions were made based on data evidence regarding operationalizing variables and

constructs and setting duration and severity criteria. These changes aimed to define more homogeneous group for purposes of scientific evolution. The B category in DSM IV TR which was phrased as "marked distress or interpersonal difficulty" have been rephrased in proposed DSM 5 in APA web site as "clinically significant distress or impairment". Although a term such as "negative personal consequences" might have covered real life personal experiences in a wider spectrum that includes not only distress but also avoidance of sexual activities and frustration due to negative experiences, the term distress is still preferred in the proposed DSM 5 APA web site (1). The wording "interpersonal difficulty" was replaced with clinically significant distress or impairment which was personal rather than interpersonal. This change probably intended to avoid labeling or stigmatizing people on the basis of their partners distress while they were not themselves bothered or distressed. It shows the increasing tendency to diagnose a sexual problem as a disorder only when it causes personal distress rather than interpersonal difficulties. Another important reason for emphasizing personal distress might be that some individuals suffering from sexual disorders do not have partners and therefore partner distress or interpersonal difficulties may not be universally applicable to all people (14,15).

The proposed APA website DSM 5 criteria called attention to subtyping all sexual disorders either as lifelong or acquired. It also referred to specifiers such as generalized or situational but deleted subtyping by etiological factors such as psychological or combined. This was probably because etiological subtyping was considered to be misleading, reductionist and was rarely shown to be accurate due to paucity of available knowledge concerning etiology. On the other hand, the specifiers in DSM 5 might be highly important for assessing the nature of the sexual problem calling attention to partner, relationship, cultural/religious, medical and individual vulnerability factors that might be crucial in the course of the disorder.

Major recommendations proposed for DSM 5 and the rationale behind these recommendations: DSM IV TR and proposed APA website DSM 5 criteria are presented in the table below (Table 1) for comparative reasons.

Table 1: Comparison of DSM IV TR and proposed APA website DSM 5 criteria

DSM IV TR CRITERIA	PROPOSED APA WEBSITE DSM 5 CRITERIA
Diagnostic criteria for 302.71 Hypoactive Sexual Desire Disorder	**Male Hypoactive Sexual Desire Disorder**
A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life. B. The disturbance causes marked distress or interpersonal difficulty. C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors	A. Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity for a minimum duration of approximately 6 months. The judgment of deficiency is made by the clinician taking into account factors that affect sexual functioning such as age and the general and sociocultural context of the individual's life. B. The problem causes clinically significant distress or impairment. C. The sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence), or other significant stressors. Subtypes: Lifelong vs. Acquired Specifiers: - Situational vs. Generalized - Partner factors (e.g., partner's sexual problems, partner's health status) - Relationship factors (e.g., poor communication, discrepancies in desire for sexual activity) - Individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression or anxiety,) or stressors (e.g., job loss, bereavement) - Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity, attitudes toward sexuality) - With medical factors relevant to prognosis, course, or treatment

Table 1: Comparison of DSM IV TR and proposed APA website DSM 5 criteria

DSM IV TR	Proposed DSM 5
Diagnostic criteria for 302.72 Male Erectile Disorder A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection. B. The disturbance causes marked distress or interpersonal difficulty. C. The erectile dysfunction is not better accounted for by another Axis I disorder (other than a Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors	**Erectile Disorder** A. A least one of the three following symptoms must have been present for a minimum duration of approximately 6 months and be expected on all or almost all (approximately 75%) occasions of sexual activity: 1. Marked difficulty in obtaining an erection during sexual activity 2. Marked difficulty in maintaining an erection until the completion of sexual activity 3. Marked decrease in erectile rigidity that interferes with sexual activity B. The problem causes clinically significant distress or impairment. C. The sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence), or other significant stressors. Subtypes: Lifelong vs. Acquired Specifiers: - Situational vs. Generalized - Partner factors (e.g., partner's sexual problems, partner's health status) - Relationship factors (e.g., poor communication, discrepancies in desire for sexual activity) - Individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression or anxiety,) or stressors (e.g., job loss, bereavement) - Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity, attitudes toward sexuality) - With medical factors relevant to prognosis, course, or treatment
Diagnostic criteria for 302.75 Premature Ejaculation A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity. B. The disturbance causes marked distress or interpersonal difficulty. C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids). Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors	**Early Ejaculation** A. The following symptom must have been present for at least 6 months and be experienced on all or almost all (approximately 75%) occasions of sexual activity: Persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately one minute of beginning of sexual activity and before the individual wishes it. Although the diagnosis may be applied to individuals engaged in non-vaginal sexual activities, no precise duration criteria are specified for such activities. B. The problem causes clinically significant distress or impairment. C. The sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence), or other significant stressors. Subtypes: Lifelong vs. Acquired Specifiers: - Situational vs. Generalized - Partner factors (e.g., partner's sexual problems, partner's health status) - Relationship factors (e.g., poor communication, discrepancies in desire for sexual activity) - Individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression or anxiety,) or stressors (e.g., job loss, bereavement) - Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity, attitudes toward sexuality) - With medical factors relevant to prognosis, course, or treatment
Sexual Dysfunction Not Otherwise Specified This category includes sexual dysfunctions that do not meet criteria for any specific Sexual Dysfunction. Examples include 1. No (or substantially diminished) subjective erotic feelings despite otherwise-normal arousal and orgasm	**Sexual Dysfunction Not Elsewhere Classified** This category includes sexual dysfunctions that do not meet criteria for any specific Sexual Dysfunction. This may include situations in which the clinician has concluded that a sexual dysfunction is present but either (1) the symptoms are atypical, mixed, or

Table 1: Comparison of DSM IV TR and proposed APA website DSM 5 criteria

2. Situations in which the clinician has concluded that a sexual dysfunction is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Diagnostic criteria for Sexual Dysfunction Due to...[Indicate the General Medical Condition]

A. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by the direct physiological effects of a general medical condition.
C. The disturbance is not better accounted for by another mental disorder (e.g.,Major Depressive Disorder).
Select code and term based on the predominant sexual dysfunction:
625.8 Female Hypoactive Sexual Desire Disorder Due to...[Indicate the General Medical Condition]: if deficient or absent sexual desire is the predominant feature
608.89 Male Hypoactive Sexual Desire Disorder Due to...[Indicate the General Medical Condition]: if deficient or absent sexual desire is the predominant feature
607.84 Male Erectile Disorder Due to...[Indicate the General Medical Condition]: if male erectile dysfunction is the predominant feature
625.0 Female Dyspareunia Due to...[Indicate the General Medical Condition]: if pain associated with intercourse is the predominant feature
608.89 Male Dyspareunia Due to...[Indicate the General Medical Condition]: if pain associated with intercourse is the predominant feature
625.8 Other Female Sexual Dysfunction Due to...[Indicate the General Medical Condition]: if some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates
608.89 Other Male Sexual Dysfunction Due to...[Indicate the General Medical Condition]: if some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates
Coding note: Include the name of the general medical condition on Axis I, e.g., 607.84 Male Erectile Disorder Due to Diabetes Mellitus; also code the general medical condition on Axis III (see Appendix G for codes).

Diagnostic criteria for Substance-Induced Sexual Dysfunction

A. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by substance use as manifested by either (1) or (2):
(1) the symptoms in Criterion A developed during, or within a month of, Substance Intoxication
(2) medication use is etiologically related to the disturbance
C. The disturbance is not better accounted for by a Sexual Dysfunction that is not substance induced. Evidence that the symptoms are better accounted for by a Sexual Dysfunction that is not substance induced might include the following: the symptoms precede the onset of the substance use or Dependence (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of intoxication, or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non-substance-induced Sexual Dysfunction (e.g., a history of recurrent non-substance-related episodes).
Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the sexual dysfunction is in excess of that usually associated with the intoxication syndrome and

below the threshold of a Sexual Dysfunction; (2) there is uncertain etiology; or (3) there is insufficient information to make a diagnosis of a current Sexual Dysfunction.

Substance/Medication-Induced Sexual Dysfunction

A. A clinically significant disturbance in sexual function in which:
1. there is evidence from the history that the disturbance in sexual function developed after beginning the substance/medication, after a dosage increase, or after discontinuation of the substance/medication; and
2. the disturbance in sexual function is not better accounted for by a disorder that is not substance/medication-induced
B. The problem causes clinically significant distress or impairment.
Code: [Specific Substance] -Induced Sexual Disorder: Alcohol;Antidepressant; Antipsychotic; Opioid; Sedative; Hypnotic; or Anxiolytic; Hormonal Contraceptives; Other (or Unknown) Substance.
Subtypes
1. Onset after beginning to take the substance/medication or after dose increase
2. Onset during withdrawal

Table 1: Comparison of DSM IV TR and proposed APA website DSM 5 criteria

when the dysfunction is sufficiently severe to warrant independent clinical attention. Code [Specific Substance]-Induced Sexual Dysfunction: (291.8 (new code as of 10/01/96: 291.89) Alcohol; 292.89 Amphetamine [or Amphetamine-Like Substance]; 292.89 Cocaine; 292.89 Opioid; 292.89 Sedative, Hypnotic, or Anxiolytic; 292.89 Other [or Unknown] Substance) Specify if: With Impaired Desire With Impaired Arousal With Impaired Orgasm With Sexual Pain Specify if: With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome Erectile Disorder Due to Diabetes Mellitus; also code the general medical condition on Axis III (see Appendix G for codes).	
Diagnostic criteria for 302.71 Hypoactive Sexual Desire Disorder A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life. B. The disturbance causes marked distress or interpersonal difficulty. C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors **Diagnostic criteria for 302.72 Female Sexual Arousal Disorder** A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement. B. The disturbance causes marked distress or interpersonal difficulty. C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors	**Female Sexual Interest/Arousal Disorder** A. Lack of sexual interest/arousal for a minimum duration of approximately 6 months as manifested by at least three of the following indicators: 1. absent/reduced frequency or intensity of interest in sexual activity4 2. absent/reduced frequency or intensity of sexual/erotic thoughts or fantasies 3. absent/reduced frequency of initiation of sexual activity and is typically unreceptive to a partner's attempts to initiate 4. absent/reduced frequency or intensity of sexual excitement/ pleasure during sexual activity on all or almost all (approximately 75%) sexual encounters 5. absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual, etc.) 6. absent/reduced frequency or intensity of genital and/or nongenital sensations during sexual activity on all or almost all (approximately 75%) sexual encounters B. The problem causes clinically significant distress or impairment. C. The sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence), or other significant stressors. Subtypes Lifelong vs. Acquired Specifiers - Situational vs. Generalized - Partner factors (e.g., partner's sexual problems, partner's health status) - Relationship factors (e.g., poor communication, discrepancies in desire for sexual activity) - Individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression or anxiety,) or stressors (e.g., job loss, bereavement) - Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity, attitudes toward sexuality) - With medical factors relevant to prognosis, course, or treatment
Diagnostic criteria for 302.73 Female Orgasmic Disorder A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the	**Female Orgasmic Disorder** A. Presence of at least one of the two following symptoms for a minimum duration of approximately 6 months, and experienced on all or almost all (approximately 75%) occasions of sexual activity: 1) Marked delay in, marked infrequency, or absence of orgasm 2) Markedly reduced intensity of orgasmic sensation B. The problem causes clinically significant distress or impairment

Table 1: Comparison of DSM IV TR and proposed APA website DSM 5 criteria

adequacy of sexual stimulation she receives. B. The disturbance causes marked distress or interpersonal difficulty. C. The orgasmic dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors	C. The sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence), or other significant stressors. Subtypes: Lifelong vs. Acquired Specifiers: - Situational vs. Generalized - Partner factors (e.g., partner's sexual problems, partner's health status) - Relationship factors (e.g., poor communication, discrepancies in desire for sexual activity) - Individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression or anxiety,) or stressors (e.g., job loss, bereavement) - Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity, attitudes toward sexuality) -With medical factors relevant to prognosis, course, or treatment
Diagnostic criteria for 306.51 Vaginismus A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. B. The disturbance causes marked distress or interpersonal difficulty. C. The disturbance is not better accounted for by another Axis I disorder (e.g., Somatization Disorder) and is not due exclusively to the direct physiological effects of a general medical condition. Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors **Diagnostic criteria for 302.76 Dyspareunia** A. Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female. B. The disturbance causes marked distress or interpersonal difficulty. C. The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except another Sexual Dysfunction), and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. Due to Combined Factors Specify type: Lifelong Type Acquired Type Specify type: Generalized Type Situational Type Specify: Due to Psychological Factors Due to Combined Factors	**Genito-Pelvic Pain/Penetration Disorder** A. Persistent or recurrent difficulties for at least 6 months with one or more of the following: 1) Marked difficulty having vaginal intercourse/penetration 2) Marked vulvovaginal or pelvic pain during vaginal intercourse/penetration attempts 3) Marked fear or anxiety either about vulvovaginal or pelvic pain or vaginal penetration 4) Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration B. The problem causes clinically significant distress or impairment C. The sexual dysfunction is not attributable to a non-sexual psychiatric disorder, by the effects of a substance/medication, by another medical condition, by severe relationship distress (e.g., partner violence), or other significant stressors. Subtype: Lifelong vs. Acquired Specifiers: 1) Generalized vs. Situational 2) With concomitant problems in sexual interest/sexual arousal 3) Partner factors (partner's sexual problems, partner's health status) 4) Relationship factors (e.g., poor communication, discrepancies in desire for sexual activity) 5) Individual vulnerability factors or psychiatric comorbidity (e.g., depression or anxiety, poor body image, history of abuse experience) 6) Cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity) 7) With medical factors relevant to prognosis, course, or treatment

The major recommendations proposed for DSM 5 (3), the rationale to make these changes and some discussions made by the authors can be summarized as follows:

1. Diagnostic classification should be separately made for males and females as women's sexual responses may not be analogous to men. Additionally given the complexity of sexual responses in women, classifications based on simple linear sexual response cycle may not be

reflecting reality.

2. Sexual aversion disorder should be deleted from the classification due to its rare diagnosis. It is suggested that people with these aversive symptoms could better be coded as sexual disorders not otherwise specified.
3. Diagnostic criteria for DSM 5 for hypoactive sexual desire disorder (HSDD) in women should be expanded to include absence of "responsive desire" defined by (16) as some women may not have spontaneous sexual desire or it may be that there is no such thing as spontaneous sexual desire (17,18). Sexual thoughts may act as an internal sexual stimuli and desire or arousal may be viewed as responses to this internal stimuli which implies that sexual desire is not spontaneous but rather a response to covert internal triggering processes (19). Additionally some women may engage in sexual activity for nonsexual reasons (without any initial direct sexual desire) such as desire of emotional closeness with their partner which may then be followed by increased desire for sexual encounter if incentives of sexual activity prove to be arousing. This increased desire following sexual arousal was termed as "responsive sexual desire" (16,20). It is also suggested that decrease in desire in HSDD should not be due to adaptive reasons such as discrepancy in sexual interest between partners and/or due to relationship problems. Additionally it is recommended to consider that the lack of desire should be beyond normal reduction expected with relationship duration and increasing age which are difficult to measure.
4. The current DSM IV TR definition on female sexual arousal disorder (FSAD) is based mainly on physiological criteria but research literature shows consistently low correlation between subjective reports of arousal and objective physiological changes that occur (21,22). The high overlap of different components of desire and arousal in women, the fact that low sexual arousal often coexist with complaints of low libido and treatment research data supporting that transdermal testosterone used for treatment of HSDD improved not only the desire but also arousal are some of the reasons that led authorities to further recommend merging desire and arousal diagnosis into one single entity called Female Sexual Interest and Arousal Disorder (FSIAD) where a certain amount of a total number of criteria are needed to be met in order to fulfill diagnostic criteria, should be adopted in DSM5 (20,23). Although the idea of merging the two disorders together is still mainly based on clinical judgement rather than sufficient empirical evidence, the suggestion has been welcomed by many professionals and is regarded as one of the most important propositions to be considered in DSM 5. Some authors (24) state that HSDD and FSAD share commonalities at the symptom level but data exists showing that they are distinguishable from each other (25). In a review made by DeRogatis in 2010, Goldstein and Goldstein suggest 3 categories such as HSDD, FSAD and FSIAD, as some women may have both desire and arousal problems while others clearly have only one (24). They emphasize the disadvantages of lumping FSD on the basis of less precise definitions that may cause more difficult to treat conditions. Other researchers welcome this merging due to unpractical and unworkable nature of DSM IV TR FSAD definition based on impaired/absent genital responses and the high overlap of the two problems (26). Impaired genital responsiveness was not found to be a valid diagnostic criteria in healthy women with or without sexual arousal disorder (17). Additionally the authors suggested that "desire not being triggered by any sexual/ erotic stimulus" should be considered as a primary or "must" criterion for diagnosis of SIAD as the diagnosis can only be made when sexual incentives are present or sufficient. Laan et al suggested that diagnosis of FSIAD should be restricted to obtaining "sexual rewards" as women who engage in sexual activity for nonsexual reasons (such as avoiding conflicts and increasing emotional closeness) desire sex for "nonsexual rewards" and may not necessarily become sexually aroused subsequently (24). On

the other hand those women who become sexually aroused following nonsexual cues and perceive it as "desire" or "arousal"can not be diagnosed as suffering from a sexual dysfunction.

5. Proposed DSM 5 criteria set up an explicit duration and severity criteria increases the diagnostic value of female orgasmic disorder (FOD). However the proposed definition of APA website DSM 5 definition deleted "following normal sexual excitement phase" part from the DSM IV TR definition.. This removal of text makes it difficult to differentiate FOD from FSIAD. The deletion may probably be due to the fact that orgasm without a previous sexual excitement is difficult to obtain and due to the difficulty to define a normal sexual excitement phase.
6. In DSM IV TR dysparenuia and vaginismus were grouped together under the topic of "sexual pain disorders". As they are considered to be distinct disorders, diagnosis made for one of them would be expected to exclude the diagnosis of the other. However, there is no empirical evidence that superficial dysparenuia can reliably be differentiated from vaginismus both for research and clinical purposes (27,28). The significant overlap between vaginismus and superficial dysparenuia on symptom dimensions make it almost impossible to reliably differentiate one from the other leaving the clinicians to consider whether they might lie on the same continuum with superficial dyspareunia sometimes extending to vaginismus (29). This is probably one of the main reasons that led some experts to propose new diagnostic criteria. The new proposed criteria for DSM 5 do not make distinction between the two and collapses them into a single diagnostic entity namely Genito-Pelvic Pain Penetration Disorder (GPPD). Another problem with both DSM IV TR and previous DSM definitions of vaginismus was the emphasis given to contraction of vaginal muscles and penetrative aspect of sexual activity, a conceptualization based on traditional penile-vaginal penetration and interference with coitus. This criterion was criticized as there is only minimal evidence for spasms of the vaginal wall. Difficulties with vaginal entry despite the woman's expressed desire to allow it, is perhaps a less specific definition but at least it does not refer to contractions as an etiological factor. Another surprising neglect in previous definitions of vaginismus was that emotional distress and fear of women were never considered as a necessary criteria for diagnosis despite the fact that most of the cases attributed the cause of the problem to the fear of pain. Additionally, appropriate treatment is generally based on the removal of fear of pain, not the muscle contractions. There was also heterogeneity involved if fear and spasm can occur only during attempts of penetration or if it can occur both at vaginal examination and penetration attempts. Such heterogeneity of core symptoms made professionals wonder if vaginismus is a single event or a symptom of different clinical conditions. Basing the definition on "interference with sex" was also not acceptable as anything including" headaches" and " watching soap operas" could also interfere with sex without necessarily being defined as a sexual disorder. Some researchers even suggested that vaginismus which is not different from dyspareunia is not a primary sexual dysfunction but a secondary reaction for the recurrent anticipated experience of genital pain and should therefore be considered as a pain disorder (30). Binik argued that many women with dyspareunia continue to be sexually active and pain emerges not only as a response to sexual intercourse attempts but also occur in other situations such as insertion of tampons and gynecological exams. However many clinicians use the term "dyspareunia" when they refer to pain of organic etiology (31) and labeling it as a psychiatric disorder may not be appropriate (3). Overall, merging superficial dyspareunia and vaginismus into GPPD in DSM 5 is welcomed by many professionals whereas Laan and Brauer debate that they can be different entities on the same continuum, with lifelong and generalized vaginismus associated with high anxiety and avoidance at one end of the spectrum and painful

intercourse with high pelvic floor tension at the other end (24). There is some evidence that women with dyspareunia and vaginismus and their partners differ in sexual behaviours and their response to pain as well (26). Additionally, the international consensus committee funded by AUAF suggested dyspareunia definition "pain associated with sexual intercourse" be changed into "pain with attempted or complete vaginal entry" as some women with dyspareunia may resist to attempts of entry because of pain expectations (3).

One might suspect why 6 months duration is needed for diagnosing GPPD. Increasing knowledge about vaginismus through media help people to recognize the disorder at a very early stage and encourage them to come forward to demand help soon after they are confronted with such a problem. Additionally, clinical experience shows that the frequency of penetration attempts are more often following initial exposure to the problem. The penetration attempts are reduced over time due to frustration and hopelessness caused by not being able to penetrate despite numerous recurrent attempts. This typical course of the disorder and its emergent nature in terms of treatment makes it difficult to understand why the diagnosis should be delayed to 6 months despite many inconclusive penetration attempts made in the first few months following initial exposure to the problem. Delaying diagnosis to six months may be risky in couples where partners may not manage to stay together due to loss of hope in solving a problem of an "emergent" nature.

7. Another issue is whether dyspareunia in men should be diagnosed with the same criteria as that in women. Dyspareunia in men is much less common and appears to involve different factors from that in women. Therefore it seems inappropriate to classify male and female dyspareunia together. Diagnosing male dyspareunia under sexual disorders not otherwise specified may be a transient solution until more data is gathered for conclusion (32).
8. Regarding Male Sexual Disorders (MSD), it is proposed to preserve the DSM IV TR criteria of HSDD with addition of minimum 6 months duration but rename the disorder as "HSDD in men" to make a separate diagnosis for males. On the contrary some authors debate gender specific definitions and claim that within gender differences are at least as frequent as between gender differences (33) and therefore suggest that FSIAD diagnosis in women may also be adopted for men. This suggestion may result in one gender neutral category. One proposition made was to apply FSIAD criteria for men as well with removal of criterion A6 (absent or reduced genital and/or non genital physical changes and sensations) as reviewed thoroughly by Brotto (23). However, the extensive literature exploring epidemiology,and treatment of ED reviewed by Segraves has presented considerable data not to subsume ED under the category of male sexual interest and arousal disorder (MSIAD) due to etiological and-or treatment reasons (34). Therefore it may be suggested that if a diagnosis like FSIAD be retained for men including A6 criterion,it may be more appropriate to add an additional qualifier to A6 that indicates "if ED symptoms are also met, then both MSIAD and ED disorders should be diagnosed" (35). The value and significance of these different propositions are likely to be understood better by further research investigating if experiences of desire and arousal can be differentiated in men, if gender differences in sexual desire may be influenced by individual psychological factors and if motivations for sex are exclusively different in males and females. There is relatively little data on men' s sexual desire when compared to the parallel research literature in women and therefore further research aimed at understanding low desire in men are required.
9. DSM 5 recommended that premature ejaculation (PE) be renamed as Early Ejaculation (EE) as the ejaculation happens before the person wishes it. Persistence of "at least 6 months duration" and frequency of "at least in 75% of all sexual encounters" criteria are included in DSM 5 diagnostic criteria for EE. DSM definitions of PE

until DSM 5 were all authority based and included terms such as "persistent, recurrent, minimal and shortly after" which were vague, multi-interpretable and lacked quantification (36). Research conducted by a committee appointed by International Society for Sexual Medicine (ISSM) in order to establish an evidence based definition for PE showed that the constructs necessary to define PE are time from penetration to ejaculation, perceived control on ejaculation and negative personal consequences (1). Intra-vaginal Ejaculation Latency Time (IELT) used to operationalize ejaculation time showed that cutoff of 1 minute captured 90% of men who actively sought treatment for EE (2,37). Therefore 1 minute duration was included in the new definition. Although perceived control to delay ejaculation was found to be an important construct, this was not adopted in DSM 5. One limitation of the evidence based definition is its application to only heterosexual men engaging in vaginal intercourse.

10. Erectile dysfunction (ED) may actually be a "symptom", even though it is often referred to as a "disorder" (38). The pervasive focus and influence of the pharmaceutical industry on ED makes it difficult to establish improved definitions for DSM 5 without conflicts of interest. A new taxonomy that helps clinicians to delineate cases of pure ED from those with ED and other sexual disorders would be very helpful. While the new DSM 5 diagnostic criteria brings an explicit duration (of at least 6 months) and severity (occurring in approximately 75% of occasions) criteria, it is difficult to assume that most men will accurately remember the frequency and duration of their failures when it comes to issues related with erections. Addition of "marked decrease in erectile rigidity" on top of the present DSM IV TR criteria of difficulty in obtaining and maintaining an erection should be discussed further. It is naturally expected to have decreases and increases in erectile rigidity during the course of sexual activity and emphasizing decrease in rigidity may increase spectatoring on patient's side, facilitate unnecessary medicalization and encourage pharmaceutical industry to promote the use of erection inducing agents when they are not exclusively indicated.

11. Male Orgasmic Disorder (MOD): DSM 5 suggests the term "Delayed Ejaculation" (DE) to be used to replace MOD. Preferring the term DE may be understandable with regards to the appropriateness of the terminology used. Men who seek help for orgasmic problems often complain about their ejaculation time. The DSM IV TR emphases on subjective experience of orgasm, whereas most clinical work is concerned with ejaculation time. However, it must be kept in mind that some orgasms occur without ejaculations and not every ejaculation is orgasmic. Additionally many clinicians and researchers also prefer to use the term "delayed ejaculation". Literature search shows more references and citations made to the term "delayed ejaculation" when compared with the term " male orgasmic disorder". In this respect it may be important to establish a congruency between diagnostic classification and current preferred daily use of the term (39). Another change suggested in DSM 5 is the addition of severity (75% of sexual occasions) and duration of complaint (6 months) criteria in order to make a more precise definition and to identify more homogeneous groups for research and other scientific purposes. On the contrary, efforts to quantify delayed ejaculation further on an intra-vaginal ejaculation time basis may be inappropriate given the wide range of time differences with different motives in delaying ejaculation. Additionally distress may emerge at different time points for different people and definition of sexual responses should not be based solely on its penetrative heterosexual nature. Although subjective sensation of orgasm is emphasized for FOD and objective genital response is emphasized in MOD, there is still an ongoing debate on whether the process of ejaculation and orgasm should be separated and whether time of ejaculation necessarily equates with the extent of orgasmic experience (40).

12. There is ongoing debate whether hypersexual disorder (HD) should be considered as a distinct diagnostic category in the sexual disorders section of DSM 5. Despite the increasing number of cases diagnosed as hypersexual, efforts are made to establish operational criteria that it is not synonymous with sexual addiction, sexual compulsivity or paraphilia related disorders (41). The risk taking dimension of HD makes it a serious condition that leads to severe complications such as unwanted pregnancies, marital discord or divorce and mortality associated with sexually transmitted diseases. Therefore HD may be conceptualized as primarily a nonparaphilic sexual desire disorder with an impulsivity and risk taking component that is vulnerable to dysphoric mood states and stressful life events. However more research is needed to fill the gaps regarding its developmental risk factors, course, prognosis and biological and psychological concomitants. Additionally there is ongoing debate about medicalizing an aberrant sexual activity that could be covered under existing diagnosis and whether including it as a distinct entity would lead to an unhelpful redundancy and criticisms in favour of anti-psychiatry movement. Implications on forensic psychiatry and the criminal justice system should also be considered (especially with specifier cybersex and pornography) to balance the costs and benefits of recognizing such a diagnosis (42).
13. Another change suggested in DSM 5 is to remove the etiological subtypes (due to psychological or combined factors) due to the paucity of lack of information concerning the etiology and add specifiers for understanding the associated features such as relationship discord, lack of attraction to current partner and sexual fantasies significantly different from current sexual activities (3).

DISCUSSION

There are some important issues that need to be considered in establishing diagnostic criteria and defining sexual dysfunctions or disorders.

One of the main issues is to define when a sexual problem becomes a sexual dysfunction. Conditions such as erectile dysfunction may indeed be symptoms of other organic disorders, may be variations along normal distributions, which represent transient conditions, or may also emerge as consequences of relationship problems and/or in response to the sexual problems of the presenting partner for adaptive purposes. Therefore making more precise definitions are required in order to differentiate disorders from other transient conditions.

One way to make more precise definitions is to establish specific duration criterion for SD just like the duration criterion required for many other mental disorders in classification systems. However, specific durations have not been part of diagnostic criteria for sexual dysfunctions until DSM 5. In the upcoming DSM 5, a duration period of more than 6 months, combined with a criterion of quite often (occurring in more than at least 75% of sexual encounters) is accepted as a defining criterion in general to distinguish sexual dysfunctions from sexual difficulties and other transient problems (3). This may be considered as a major advancement in defining more homogeneous groups for diagnostic purposes. If the same duration and frequency criteria will be accepted for all of the SD then it may be reasonable to add “more than 6 months and more than 75% of sexual encounters” as a new criterion set just like the common B criterion for all SD. However adding a standard (6 months) duration criteria for all SD as suggested for DSM 5 may cause delay as DSM 5 diagnosis cannot be given until symptoms have been experienced for at least 6 months. This may not be the case for some sexual dysfunctions such as vaginismus where a period of 6 months duration may be an unnecessary to diagnose the disorder. Inexperienced therapists who are sticking only to diagnostic criteria may delay to make a diagnosis and therefore also delay to give a treatment without a diagnosis. This might cause further problems due to the emergent and culturally demanding nature of the problem.

Since an impairment of sexual functions does

not necessarily cause distress for that person it is important to emphasize that marked "personal distress" rather than "interpersonal distress" is an important requirement for classifying a problem as a sexual dysfunction. In DSM 5 a criterion such as "the problem causes clinically significant distress or impairment" seems to be accepted in general as a requirement to define all sexual dysfunctions. This change in wording probably intended to avoid labeling or stigmatizing people on the basis of their partners distress while they were not themselves bothered or distressed. It shows the increasing tendency to diagnose a sexual problem as a disorder only when it causes personal distress rather than interpersonal difficulties.

Drifting apart from unidimensional linear sexual response cycle for both genders may be seen as an advancement in terms of establishing more specific diagnostic criteria for different genders. However despite the present considerable data available to propose that sexual interest, motivation, arousal and pleasure may be experienced differently in different genders, it is still a question of debate whether there is enough evidence to lump sexual interest and arousal disorders in females into one category namely "female sexual interest/arousal disorder" as suggested in DSM 5. Whether to lump or split sexual disorders should be based on the costs and benefits of each option (42).

Some clinicians and researchers believe that female sexual dysfunctions are a spectrum of disorders with extensive overlap and therefore could not be diagnosed specifically (43,44). On the other hand, if there are two naturally occurring distinct conditions present, with unique characteristics which show phenomenological overlap at the symptom level, the risks of merging them in DSM 5 may be substantial in terms of clinical practice and research. In the DeRogatis paper, Goldstein & Goldstein emphasizes the significance of protecting the women from having their problems lumped in a way that makes providing treatments more difficult (25). Therefore, it is expected that there will be further discussions and debates regarding whether this lumping is based on evidence or expert opinions.

Apart from gender differences, research results reflect diversity in members of the same gender as well. Women's motivations for sex might be different from each other, and there is evidence that responsive desire occurs in women with and without arousal difficulties. It is recommended that relationship duration and sufficiency of partner sexual stimulation must be recognized in future diagnostic framework of dysfunctions (45).

Before DSM 5 the terms "premature ejaculation" and "vaginismus" were only used to define sexual dysfunctions that interfered with vaginal intercourse. Such a restriction was seen unnecessary as the diagnosis could not be based on interference with vaginal entry. As DSM 5 emphasizes more on fear and anxiety of pain instead of muscle contractions, this may be considered as an advancement for diagnostic purposes. The term "Genito-Pelvic Pain/Penetration Disorder" is also better than the term "Vaginismus" as the latter implies contraction of muscles and ignores the women's anxiety and fear. However there is room for improvement in diagnostic criteria for both Early Ejaculation and Genito-Pelvic Pain/ Penetration due to excluding homosexual orientation and non penetrative sexual activities and people without partners. There is also lack of research regarding homosexuals and heterosexuals for whom vaginal intercourse is not part of their sexual repertoire. Another issue that needed to be considered in diagnosis of PE before DSM 5 was to operationalize ejaculation time as there were no precise definitions made for IELT. Although an operational criteria such as one minute IELT in DSM 5 may be considered as a major advancement to evolve scientific progress there is still room for improvement as no precise duration criteria are specified for non-vaginal sexual activities (1,2).

It seems like there is need for further research evidence to conclude about diagnostic criteria for different SD.

All of these discussions, critiques and challenges are made within the limitations of the proposed APA website DSM 5 criteria which is now removed from the internet. Further discussions will be made when official DSM 5 criteria are released.

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