*As the American Psychiatric Association committees begin formal work on DSM-V, we welcome brief editorials on issues that should be considered in its formulation.*

# Issues for DSM-V: Sexual Dysfunction, Disorder, or Variation Along Normal Distribution: Toward Rethinking DSM Criteria of Sexual Dysfunctions

Human sexuality lately has become one of psychiatry's Cinderellas. That status has been reflected, among others, in the lack of movement in sharpening and redefining of the diagnostic criteria, and the lack of operational criteria for diagnosing human sexual dysfunctions/disorders similar to the operational criteria for diagnosing other mental disorders.

In our view, three important issues that need to be addressed in the next revision of DSM are 1) when does a sexual problem become a sexual dysfunction (1), 2) whether there should be a specific duration criterion for sexual dysfunction(s) akin to the duration criterion for many other mental disorders, and 3) whether distress (used across DSM) should be used as a diagnostic criterion of sexual disorders. These issues are actually intertwined.

*"When does a sexual problem become a sexual dysfunction?"*

According to the analysis by Laumann et al. (2) of the National Health and Social Life Survey, the prevalence of sexual dysfunction in the United States is 43% for women and 31% for men. However, as Bancroft et al. (1) pointed out, it is not clear what proportion of problems identified in this and other epidemiological studies as sexual dysfunction could be best identified as "adaptive or understandable reactions to current circumstances." Discussing methodological problems across epidemiological studies, such as questions about the frequency of dysfunction and different periods of duration (e.g., previous year [2] or previous 3 months [3]), Bancroft et al. suggested that we need to be cautious about estimating the prevalence of "sexual dysfunction" in the population. We propose that sexual dysfunction needs to be separated from transient alterations of sexual behavior related to life stress, interpersonal problems, or due to various other disorders (which could be defined, for example, as adjustment disorder with sexual dysfunction, sexual dysfunction due to mental disorder, or sexual dysfunction due to a general medical condition).

The DSM criteria for many disorders include the duration of illness or disturbance, ranging from weeks to 6 months. However, duration is not a part of the diagnostic criteria for sexual dysfunctions. Yet, including a duration criterion of 6 months, for example, may help to identify more homogenous group(s) and distinguish sexual dysfunction(s) from transient alterations of sexual behavior due to stress. In a study by Mercer et al. (4), persistent sexual problems lasting at least 6 months in the preceding year (6.2% of men and 15.6% of women) were less frequent than sexual dysfunction lasting 1 month and less frequent than estimates of sexual dysfunction in other studies (e.g., 31% and 43% respectively in the Laumann et al. study [2]). We believe that the duration criterion of 6 months should be added to the future diagnostic criteria together with a refined (e.g., frequency or occurrence at a specific percentage of the time) definition of specific sexual dysfunction.

Marked distress or interpersonal difficulty is a criterion of all DSM-defined sexual dysfunctions. Intuitively this criterion helps to delineate a disorder or dysfunction from a normal variant of functioning. However, some studies (e.g., that of Bancroft et al. [1]) that estimated the prevalence of sexual dysfunction did not ask about distress, or found that a significant portion of those suffering from sexual dysfunction were not distressed by it. Oberg et al. (5) noted that less than 45% of Swedish women with manifest low in-

terest and orgasm perceived these dysfunctions as distressing. Waldinger and Schweitzer (6, 7) argue that the distress criterion is not useful in defining premature ejaculation, since there are many men with this dysfunction without marked distress or interpersonal difficulty. This way men whose time to ejaculation is 2 minutes may be grouped with men whose time to ejaculation is more than 12 minutes because of poor specificity combined with the distress criterion. They also suggest that in some men, premature or rapid ejaculation is not based on neurobiological or psychological pathology but is rather a normal variant of sexual performance. We propose that the addition of distress/interpersonal difficulty to the diagnostic criteria of sexual dysfunctions be reevaluated in view of the evidence that some persons with sexual dysfunction are not distressed by it. If this criterion is retained, the distress should be clearly defined in terms such as causing concerns, worry, or anxiety or disrupting the nonsexual aspects of the relationship. As Waldinger and Schweitzer suggest (7), the severity of the dysfunction could also be expressed by different degrees of distress and interpersonal difficulty.

A whole host of other issues could be reevaluated. Some (8) believe that female sexual dysfunction does not exist as a specific diagnosis, since it is a spectrum of disorders with extensive overlap between them. The diagnostic criteria of sexual dysfunctions are anchored in the particular phases of the sexual response cycle. However, frequently, sexual dysfunction does not happen in isolation as a dysfunction of only one phase of the sexual response cycle. Furthermore, an international group of experts (9) recently suggested reevaluating the entire area of female sexual dysfunction. They proposed adding a lack of responsive desire to the criteria of female hypoactive sexual desire disorder. This group also noted that cognitive and genital measures of arousal are poorly correlated and thus suggested creating diagnostic categories such as subjective sexual arousal disorder, combined genital and subjective sexual arousal disorder, and genital sexual arousal disorder. Another proposal for change comes from Binik (10), who suggests that dyspareunia should not be classified as a sexual dysfunction but as a pain disorder. We also feel that the area of diagnosis of female sexual dysfunction should be evaluated carefully in view of a controversial suggestion that the pharmaceutical industry has created a new "disease" of female sexual dysfunction (11).

We hope that at least the issues of sexual problem versus sexual dysfunction, duration of sexual dysfunction, and the use of distress as a diagnostic criterion will be addressed in the next DSM edition. As for the remaining issues, we can only hope that they will also be discussed and evaluated as the diagnosis of sexual dysfunction is refined.

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