Sexual Dysfunctions

Sexual dysfunctions include delayed ejaculation, erectile disorder, female orgasmic disorder, female sexual interest/arousal disorder, genito-pelvic pain/penetration disorder, male hypoactive sexual desire disorder, premature (early) ejaculation, substance/medication-induced sexual dysfunction, other specified sexual dysfunction, and unspecified sexual dysfunction. Sexual dysfunctions are a heterogeneous group of disorders that are typically characterized by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure. An individual may have several sexual dysfunctions at the same time. In such cases, all of the dysfunctions should be diagnosed.

Clinical judgment should be used to determine if the sexual difficulties are the result of inadequate sexual stimulation; in these cases, there may still be a need for care, but a diagnosis of a sexual dysfunction would not be made. These cases may include, but are not limited to, conditions in which lack of knowledge about effective stimulation prevents the experience of arousal or orgasm.

Subtypes are used to designate the onset of the difficulty. In many individuals with sexual dysfunctions, the time of onset may indicate different etiologies and interventions. *Lifelong* refers to a sexual problem that has been present from first sexual experiences, and *acquired* applies to sexual disorders that develop after a period of relatively normal sexual function. *Generalized* refers to sexual difficulties that are not limited to certain types of stimulation, situations, or partners, and *situational* refers to sexual difficulties that only occur with certain types of stimulation, situations, or partners.

In addition to the lifelong/acquired and generalized/situational subtypes, a number of factors must be considered during the assessment of sexual dysfunction, given that they may be relevant to etiology and/or treatment, and that may contribute, to varying degrees, across individuals: 1) partner factors (e.g., partner's sexual problems; partner's 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 5) medical factors relevant to prognosis, course, or treatment.

Clinical judgment about the diagnosis of sexual dysfunction should take into consideration cultural factors that may influence expectations or engender prohibitions about the experience of sexual pleasure. Aging may be associated with a normative decrease in sexual response.

Sexual response has a requisite biological underpinning, yet is usually experienced in an intrapersonal, interpersonal, and cultural context. Thus, sexual function involves a complex interaction among biological, sociocultural, and psychological factors. In many clinical contexts, a precise understanding of the etiology of a sexual problem is unknown. Nonetheless, a sexual dysfunction diagnosis requires ruling out problems that are better explained by a nonsexual mental disorder, by the effects of a substance (e.g., drug or medication), by a medical condition (e.g., due to pelvic nerve damage), or by severe relationship distress, partner violence, or other stressors.

If the sexual dysfunction is mostly explainable by another nonsexual mental disorder (e.g., depressive or bipolar disorder, anxiety disorder, posttraumatic stress disorder, psychotic dis-

order), then only the other mental disorder diagnosis should be made. If the problem is thought to be better explained by the use/misuse or discontinuation of a drug or substance, it should be diagnosed accordingly as a substance/medication-induced sexual dysfunction. If the sexual dysfunction is attributable to another medical condition (e.g., peripheral neuropathy), the individual would not receive a psychiatric diagnosis. If severe relationship distress, partner violence, or significant stressors better explain the sexual difficulties, then a sexual dysfunction diagnosis is not made, but an appropriate V or Z code for the relationship problem or stressor may be listed. In many cases, a precise etiological relationship between another condition (e.g., a medical condition) and a sexual dysfunction cannot be established.

Delayed Ejaculation

Diagnostic Criteria 302.74 (F52.32)

A. Either of the following symptoms must be experienced on almost all or all occasions (approximately 75%–100%) of partnered sexual activity (in identified situational contexts or, if generalized, in all contexts), and without the individual desiring delay:
   1. Marked delay in ejaculation.
   2. Marked infrequency or absence of ejaculation.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.
Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:

Generalized: Not limited to certain types of stimulation, situations, or partners.
Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify current severity:

Mild: Evidence of mild distress over the symptoms in Criterion A.
Moderate: Evidence of moderate distress over the symptoms in Criterion A.
Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

The distinguishing feature of delayed ejaculation is a marked delay in or inability to achieve ejaculation (Criterion A). The man reports difficulty or inability to ejaculate despite the presence of adequate sexual stimulation and the desire to ejaculate. The presenting complaint usually involves partnered sexual activity. In most cases, the diagnosis will be made by self-report of the individual. The definition of "delay" does not have precise boundaries, as there is noconsensus as to what constitutes a reasonable time to reach orgasm or what is unacceptably long for most men and their sexual partners.

Associated Features Supporting Diagnosis

The man and his partner may report prolonged thrusting to achieve orgasm to the point of exhaustion or genital discomfort and then ceasing efforts. Some men may report avoiding

sexual activity because of a repetitive pattern of difficulty ejaculating. Some sexual partners may report feeling less sexually attractive because their partner cannot ejaculate easily.

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of delayed ejaculation, given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's 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/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different men with this disorder.

Prevalence

Prevalence is unclear because of the lack of a precise definition of this syndrome. It is the least common male sexual complaint. Only 75% of men report always ejaculating during sexual activity, and less than 1% of men will complain of problems with reaching ejaculation that last more than 6 months.

Development and Course

Lifelong delayed ejaculation begins with early sexual experiences and continues throughout life. By definition, acquired delayed ejaculation begins after a period of normal sexual function. There is minimal evidence concerning the course of acquired delayed ejaculation. The prevalence of delayed ejaculation appears to remain relatively constant until around age 50 years, when the incidence begins to increase significantly. Men in their 80s report twice as much difficulty ejaculating as men younger than 59 years.

Risk and Prognostic Factors

Genetic and physiological. Age-related loss of the fast-conducting peripheral sensory nerves and age-related decreased sex steroid secretion may be associated with the increase in delayed ejaculation in men older than 50 years.

Culture-Related Diagnostic Issues

Complaints of ejaculatory delay vary across countries and cultures. Such complaints are more common among men in Asian populations than in men living in Europe, Australia, or the United States. This variation may be attributable to cultural or genetic differences between cultures.

Functional Consequences of Delayed Ejaculation

Difficulty with ejaculation may contribute to difficulties in conception. Delayed ejaculation is often associated with considerable psychological distress in one or both partners.

Differential Diagnosis

Another medical condition. The major differential diagnosis is between delayed ejaculation fully explained by another medical illness or injury and delayed ejaculation with a psychogenic, idiopathic, or combined psychological and medical etiology. A situational aspect to the complaint is suggestive of a psychological basis for the problem (e.g., men who can ejaculate during sexual activity with one sex but not the other; men who can ejaculate with one partner but not another of the same sex; men with paraphilic arousal pat-

terns; men who require highly ritualized activity to ejaculate during partnered sexual activity). Another medical illness or injury may produce delays in ejaculation independent of psychological issues. For example, inability to ejaculate can be caused by interruption of the nerve supply to the genitals, such as can occur after traumatic surgical injury to the lumbar sympathetic ganglia, abdominoperitoneal surgery, or lumbar sympathectomy. Ejaculation is thought to be under autonomic nervous system control involving the hypogastric (sympathetic) and pudendal (parasympathetic) nerves. A number of neurodegenerative diseases, such as multiple sclerosis and diabetic and alcoholic neuropathy, can cause inability to ejaculate. Delayed ejaculation should also be differentiated from retrograde ejaculation (i.e., ejaculation into the bladder), which may follow transurethral prostatic resection.

Substance/medication use. A number of pharmacological agents, such as antidepressants, antipsychotics, alpha sympathetic drugs, and opioid drugs, can cause ejaculatory problems.

Dysfunction with orgasm. It is important in the history to ascertain whether the complaint concerns delayed ejaculation or the sensation of orgasm, or both. Ejaculation occurs in the genitals, whereas the experience of orgasm is believed to be primarily subjective. Ejaculation and orgasm usually occur together but not always. For example, a man with a normal ejaculatory pattern may complain of decreased pleasure (i.e., anhedonic ejaculation). Such a complaint would not be coded as delayed ejaculation but could be coded as other specified sexual dysfunction or unspecified sexual dysfunction.

Comorbidity

There is some evidence to suggest that delayed ejaculation may be more common in severe forms of major depressive disorder.

Erectile Disorder

Diagnostic Criteria **302.72 (F52.21)**

A. At least one of the three following symptoms must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
   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.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.

Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:

Generalized: Not limited to certain types of stimulation, situations, or partners.

Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify current severity:

Mild: Evidence of mild distress over the symptoms in Criterion A.

Moderate: Evidence of moderate distress over the symptoms in Criterion A.

Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

The essential feature of erectile disorder is the repeated failure to obtain or maintain erections during partnered sexual activities (Criterion A). A careful sexual history is necessary to ascertain that the problem has been present for a significant duration of time (i.e., at least approximately 6 months) and occurs on the majority of sexual occasions (i.e., at least 75% of the time). Symptoms may occur only in specific situations involving certain types of stimulation or partners, or they may occur in a generalized manner in all types of situations, stimulation, or partners.

Associated Features Supporting Diagnosis

Many men with erectile disorder may have low self-esteem, low self-confidence, and a decreased sense of masculinity, and may experience depressed affect. Fear and/or avoidance of future sexual encounters may occur. Decreased sexual satisfaction and reduced sexual desire in the individual's partner are common.

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of erectile disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's 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/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different men with this disorder.

Prevalence

The prevalence of lifelong versus acquired erectile disorder is unknown. There is a strong age-related increase in both prevalence and incidence of problems with erection, particularly after age 50 years. Approximately 13%–21% of men ages 40–80 years complain of occasional problems with erections. Approximately 2% of men younger than age 40–50 years complain of frequent problems with erections, whereas 40%–50% of men older than 60–70 years may have significant problems with erections. About 20% of men fear erectile problems on their first sexual experience, whereas approximately 8% experienced erectile problems that hindered penetration during their first sexual experience.

Development and Course

Erectile failure on first sexual attempt has been found to be related to having sex with a previously unknown partner, concomitant use of drugs or alcohol, not wanting to have sex, and peer pressure. There is minimal evi-2t most of these problems spontaneously remit without professional intervention, but some men may continue to have episodic problems. In contrast, acquired erectile disorder is often associated with biological factors such as diabetes and cardiovascular disease. Acquired erectile disorder is likely to be persistent in most men.

The natural history of lifelong erectile disorder is unknown. Clinical observation supports the association of lifelong erectile disorder with psychological factors that are self-

limiting or responsive to psychological interventions, whereas, as noted above, acquired erectile disorder is more likely to be related to biological factors and to be persistent. The incidence of erectile disorder increases with age. A minority of men diagnosed as having moderate erectile failure may experience spontaneous remission of symptoms without medical intervention. Distress associated with erectile disorder is lower in older men as compared with younger men.

Risk and Prognostic Factors

Temperamental. Neurotic personality traits may be associated with erectile problems in college students, and submissive personality traits may be associated with erectile problems in men age 40 years and older. *Alexithymia* (i.e., deficits in cognitive processing of emotions) is common in men diagnosed with "psychogenic" erectile dysfunction. Erectile problems are common in men diagnosed with depression and posttraumatic stress disorder.

Course modifiers. Risk factors for acquired erectile disorder include age, smoking tobacco, lack of physical exercise, diabetes, and decreased desire.

Culture-Related Diagnostic Issues

Complaints of erectile disorder have been found to vary across countries. It is unclear to what extent these differences represent differences in cultural expectations as opposed to genuine differences in the frequency of erectile failure.

Diagnostic Markers

Nocturnal penile tumescence testing and measured erectile turgidity during sleep can be employed to help differentiate organic from psychogenic erectile problems on the assumption that adequate erections during rapid eye movement sleep indicate a psychological etiology to the problem. A number of other diagnostic procedures may be employed depending on the clinician's assessment of their relevance given the individual's age, comorbid medical problems, and clinical presentation. Doppler ultrasonography and intravascular injection of vasoactive drugs, as well as invasive diagnostic procedures such as dynamic infusion cavernosography, can be used to assess vascular integrity. Pudendal nerve conduction studies, including somatosensory evoked potentials, can be employed when a peripheral neuropathy is suspected. In men also complaining of decreased sexual desire, serum bioavailable or free testosterone is frequently assessed to determine if the difficulty is secondary to endocrinological factors. Thyroid function may also be assessed. Determination of fasting serum glucose is useful to screen for the presence of diabetes mellitus. The assessment of serum lipids is important, as erectile disorder in men 40 years and older is predictive of the future risk of coronary artery disease.

Functional Consequences of Erectile Disorder

Erectile disorder can interfere with fertility and produce both individual and interpersonal distress. Fear and/or avoidance of sexual encounters may interfere with the ability to develop intimate relationships.

Differential Diagnosis

Nonsexual mental disorders. Major depressive disorder and erectile disorder are closely associated, and erectile disorder accompanying severe depressive disorder may occur.

Normal erectile function. The differential should include consideration of normal erectile function in men with excessive expectations.

Substance/medication use. Another major differential diagnosis is whether the erectile problem is secondary to substance/medication use. An onset that coincides with the beginning of substance/medication use and that dissipates with discontinuation of the substance/medication or dose reduction is suggestive of a substance/medication-induced sexual dysfunction.

Another medical condition. The most difficult aspect of the differential diagnosis of erectile disorder is ruling out erectile problems that are fully explained by medical factors. Such cases would not receive a diagnosis of a mental disorder. The distinction between erectile disorder as a mental disorder and erectile dysfunction as the result of another medical condition is usually unclear, and many cases will have complex, interactive biological and psychiatric etiologies. If the individual is older than 40–50 years and/or has concomitant medical problems, the differential diagnosis should include medical etiologies, especially vascular disease. The presence of an organic disease known to cause erectile problems does not confirm a causal relationship. For example, a man with diabetes mellitus can develop erectile disorder in response to psychological stress. In general, erectile dysfunction due to organic factors is generalized and gradual in onset. An exception would be erectile problems after traumatic injury to the nervous innervation of the genital organs (e.g., spinal cord injury). Erectile problems that are situational and inconsistent and that have an acute onset after a stressful life event are most often due to psychological events. An age of less than 40 years is also suggestive of a psychological etiology to the difficulty.

Other sexual dysfunctions. Erectile disorder may coexist with premature (early) ejaculation and male hypoactive sexual desire disorder.

Comorbidity

Erectile disorder can be comorbid with other sexual diagnoses, such as premature (early) ejaculation and male hypoactive sexual desire disorder, as well as with anxiety and depressive disorders. Erectile disorder is common in men with lower urinary tract symptoms related to prostatic hypertrophy. Erectile disorder may be comorbid with dyslipidemia, cardiovascular disease, hypogonadism, multiple sclerosis, diabetes mellitus, and other diseases that interfere with the vascular, neurological, or endocrine function necessary for normal erectile function.

Relationship to International Classification of Diseases

Erectile response is coded as failure of genital response in ICD-10 (F2.2).

Female Orgasmic Disorder

Diagnostic Criteria **302.73 (F52.31)**

A. Presence of either of the following symptoms and experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
   1. Marked delay in, marked infrequency of, or absence of orgasm.
   2. Markedly reduced intensity of orgasmic sensations.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant

stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.

Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:

Generalized: Not limited to certain types of stimulation, situations, or partners.

Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify if:

Never experienced an orgasm under any situation.

Specify current severity:

Mild: Evidence of mild distress over the symptoms in Criterion A.

Moderate: Evidence of moderate distress over the symptoms in Criterion A.

Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

Female orgasmic disorder is characterized by difficulty experiencing orgasm and/or markedly reduced intensity of orgasmic sensations (Criterion A). Women show wide variability in the type or intensity of stimulation that elicits orgasm. Similarly, subjective descriptions of orgasm are extremely varied, suggesting that it is experienced in very different ways, both across women and on different occasions by the same woman. For a diagnosis of female orgasmic disorder, symptoms must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts) and have a minimum duration of approximately 6 months. The use of the minimum severity and duration criteria is intended to distinguish transient orgasm difficulties from more persistent orgasmic dysfunction. The inclusion of "approximately" in Criterion B allows for clinician judgment in cases in which symptom duration does not meet the recommended 6-month threshold.

For a woman to have a diagnosis of female orgasmic disorder, clinically significant distress must accompany the symptoms (Criterion C). In many cases of orgasm problems, the causes are multifactorial or cannot be determined. If female orgasmic disorder is deemed to be better explained by another mental disorder, the effects of a substance/medication, or a medical condition, then a diagnosis of female orgasmic disorder would not be made. Finally, if interpersonal or significant contextual factors, such as severe relationship distress, intimate partner violence, or other significant stressors, are present, then a diagnosis of female orgasmic disorder would not be made.

Many women require clitoral stimulation to reach orgasm, and a relatively small proportion of women report that they always experience orgasm during penile-vaginal intercourse. Thus, a woman's experiencing orgasm through clitoral stimulation but not during intercourse does not meet criteria for a clinical diagnosis of female orgasmic disorder. It is also important to consider whether orgasmic difficulties are the result of inadequate sexual stimulation; in these cases, there may still be a need for care, but a diagnosis of female orgasmic disorder would not be made.

Associated Features Supporting Diagnosis

Associations between specific patterns of personality traits or psychopathology and orgasmic dysfunction have generally not been supported. Compared with women without the disorder, some women with female orgasmic disorder may have greater difficulty communicating about sexual issues. Overall sexual satisfaction, however, is not strongly correlated with orgasmic experience. Many women report high levels of sexual satisfaction

despite rarely or never experiencing orgasm. Orgasmic difficulties in women often co-occur with problems related to sexual interest and arousal.

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of female orgasmic disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's 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/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different women with this disorder.

Prevalence

Reported prevalence rates for female orgasmic problems in women vary widely, from 10% to 42%, depending on multiple factors (e.g., age, culture, duration, and severity of symptoms); however, these estimates do not take into account the presence of distress. Only a proportion of women experiencing orgasm difficulties also report associated distress. Variation in how symptoms are assessed (e.g., the duration of symptoms and the recall period) also influence prevalence rates. Approximately 10% of women do not experience orgasm throughout their lifetime.

Development and Course

By definition, lifelong female orgasmic disorder indicates that the orgasmic difficulties have always been present, whereas the acquired subtype would be assigned if the woman's orgasmic difficulties developed after a period of normal orgasmic functioning.

A woman's first experience of orgasm can occur any time from the prepubertal period to well into adulthood. Women show a more variable pattern in age at first orgasm than do men, and women's reports of having experienced orgasm increase with age. Many women learn to experience orgasm as they experience a wide variety of stimulation and acquire more knowledge about their bodies. Women's rates of orgasm consistency (defined as "usually or always" experiencing orgasm) are higher during masturbation than during sexual activity with a partner.

Risk and Prognostic Factors

Temperamental. A wide range of psychological factors, such as anxiety and concerns about pregnancy, can potentially interfere with a woman's ability to experience orgasm.

Environmental. There is a strong association between relationship problems, physical health, and mental health and orgasm difficulties in women. Sociocultural factors (e.g., gender role expectations and religious norms) are also important influences on the experience of orgasmic difficulties.

Genetic and physiological. Many physiological factors may influence a woman's experience of orgasm, including medical conditions and medications. Conditions such as multiple sclerosis, pelvic nerve damage from radical hysterectomy, and spinal cord injury can all influence orgasmic functioning in women. Selective serotonin reuptake inhibitors are known to delay or inhibit orgasm in women. Women with vulvovaginal atrophy (characterized by symptoms such as vaginal dryness, itching, and pain) are significantly more likely to report orgasm difficulties than are women without this condition. Menopausal status is not consistently associated with the likelihood of orgasm difficulties. There may be a significant genetic contribution to variation in female orgasmic function. However,

psychological, sociocultural, and physiological factors likely interact in complex ways to influence women's experience of orgasm and of orgasm difficulties.

Culture-Related Diagnostic Issues

The degree to which lack of orgasm in women is regarded as a problem that requires treatment may vary depending on cultural context. In addition, women differ in how important orgasm is to their sexual satisfaction. There may be marked sociocultural and generational differences in women's orgasmic ability. For example, the prevalence of inability to reach orgasm has ranged from 17.7% (in Northern Europe) to 42.2% (in Southeast Asia).

Diagnostic Markers

Although measurable physiological changes occur during female orgasm, including changes in hormones, pelvic floor musculature, and brain activation, there is significant variability in these indicators of orgasm across women. In clinical situations, the diagnosis of female orgasmic disorder is based on a woman's self-report.

Functional Consequences of Female Orgasmic Disorder

The functional consequences of female orgasmic disorder are unclear. Although there is a strong association between relationship problems and orgasmic difficulties in women, it is unclear whether relationship factors are risk factors for orgasmic difficulties or are consequences of those difficulties.

Differential Diagnosis

Nonsexual mental disorders. Nonsexual mental disorders, such as major depressive disorder, which is characterized by markedly diminished interest or pleasure in all, or almost all, activities, may explain female orgasmic disorder. If the orgasmic difficulties are better explained by another mental disorder, then a diagnosis of female orgasmic disorder would not be made.

Substance/medication-induced sexual dysfunction. Substance/medication use may explain the orgasmic difficulties.

Another medical condition. If the disorder is due to another medical condition (e.g., multiple sclerosis, spinal cord injury), then a diagnosis of female orgasmic disorder would not be made.

Interpersonal factors. If interpersonal or significant contextual factors, such as severe relationship distress, intimate partner violence, or other significant stressors, are associated with the orgasmic difficulties, then a diagnosis of female orgasmic disorder would not be made.

Other sexual dysfunctions. Female orgasmic disorder may occur in association with other sexual dysfunctions (e.g., female sexual interest/arousal disorder). The presence of another sexual dysfunction does not rule out a diagnosis of female orgasmic disorder. Occasional orgasmic difficulties that are short-term or infrequent and are not accompanied by clinically significant distress or impairment are not diagnosed as female orgasmic disorder. A diagnosis is also not appropriate if the problems are the result of inadequate sexual stimulation.

Comorbidity

Women with female orgasmic disorder may have co-occurring sexual interest/arousal difficulties. Women with diagnoses of other nonsexual mental disorders, such as major depressive disorder, may experience lower sexual interest/arousal, and this may indirectly increase the likelihood of orgasmic difficulties.

Female Sexual Interest/Arousal Disorder

Diagnostic Criteria 302.72 (F52.22)

A. Lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following:
   1. Absent/reduced interest in sexual activity.
   2. Absent/reduced sexual/erotic thoughts or fantasies.
   3. No/reduced initiation of sexual activity, and typically unreceptive to a partner's attempts to initiate.
   4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
   5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
   6. Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.

Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:

Generalized: Not limited to certain types of stimulation, situations, or partners.

Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify current severity:

Mild: Evidence of mild distress over the symptoms in Criterion A.

Moderate: Evidence of moderate distress over the symptoms in Criterion A.

Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

In assessing female sexual interest/arousal disorder, interpersonal context must be taken into account. A "desire discrepancy," in which a woman has lower desire for sexual activity than her partner, is not sufficient to diagnose female sexual interest/arousal disorder. In order for the criteria for the disorder to be met, there must be absence or reduced frequency or intensity of at least three of six indicators (Criterion A) for a minimum duration of approximately 6 months (Criterion B). There may be different symptom profiles across women, as well as variability in how sexual interest and arousal are expressed. For example, in one woman, sexual interest/arousal disorder may be expressed as a lack of interest in sexual activity, an absence of erotic or sexual thoughts, and reluctance to initiate sexual activity and respond to a partner's sexual invitations. In another woman, an inability to become sexually excited, to respond to sexual stimuli with sexual desire, and a correspond-

ing lack of signs of physical sexual arousal may be the primary features. Because sexual desire and arousal frequently coexist and are elicited in response to adequate sexual cues, the criteria for female sexual interest/arousal disorder take into account that difficulties in desire and arousal often simultaneously characterize the complaints of women with this disorder. Short-term changes in sexual interest or arousal are common and may be adaptive responses to events in a woman's life and do not represent a sexual dysfunction. Diagnosis of female sexual interest/arousal disorder requires a minimum duration of symptoms of approximately 6 months as a reflection that the symptoms must be a persistent problem. The estimation of persistence may be determined by clinical judgment when a duration of 6 months cannot be ascertained precisely.

There may be absent or reduced frequency or intensity of interest in sexual activity (Criterion A1), which was previously termed *hypoactive sexual desire disorder*. The frequency or intensity of sexual and erotic thoughts or fantasies may be absent or reduced (Criterion A2). The expression of fantasies varies widely across women and may include memories of past sexual experiences. The normative decline in sexual thoughts with age should be taken into account when this criterion is being assessed. Absence or reduced frequency of initiating sexual activity and of receptivity to a partner's sexual invitations (Criterion A3) is a behaviorally focused criterion. A couple's beliefs and preferences for sexual initiation patterns are highly relevant to the assessment of this criterion. There may be absent or reduced sexual excitement or pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (Criterion A4). Lack of pleasure is a common presenting clinical complaint in women with low desire. Among women who report low sexual desire, there are fewer sexual or erotic cues that elicit sexual interest or arousal (i.e., there is a lack of "responsive desire"). Assessment of the adequacy of sexual stimuli will assist in determining if there is a difficulty with responsive sexual desire (Criterion A5). Frequency or intensity of genital or nongenital sensations during sexual activity may be reduced or absent (Criterion A6). This may include reduced vaginal lubrication/vasocongestion, but because physiological measures of genital sexual response do not differentiate women who report sexual arousal concerns from those who do not, the self-report of reduced or absent genital or nongenital sensations is sufficient.

For a diagnosis of female sexual interest/arousal disorder to be made, clinically significant distress must accompany the symptoms in Criterion A. Distress may be experienced as a result of the lack of sexual interest/arousal or as a result of significant interference in a woman's life and well-being. If a lifelong lack of sexual desire is better explained by one's self-identification as "asexual," then a diagnosis of female sexual interest/arousal disorder would not be made.

Associated Features Supporting Diagnosis

Female sexual interest/arousal disorder is frequently associated with problems in experiencing orgasm, pain experienced during sexual activity, infrequent sexual activity, and couple-level discrepancies in desire. Relationship difficulties and mood disorders are also frequently associated features of female sexual interest/arousal disorder. Unrealistic expectations and norms regarding the "appropriate" level of sexual interest or arousal, along with poor sexual techniques and lack of information about sexuality, may also be evident in women diagnosed with female sexual interest/arousal disorder. The latter, as well as normative beliefs about gender roles, are important factors to consider.

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of female sexual interest/arousal disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's 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/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and

5) medical factors relevant to prognosis, course, or treatment. Note that each of these factors may contribute differently to the presenting symptoms of different women with this disorder.

Prevalence

The prevalence of female sexual interest/arousal disorder, as defined in this manual, is unknown. The prevalence of low sexual desire and of problems with sexual arousal (with and without associated distress), as defined by DSM-IV or ICD-10, may vary markedly in relation to age, cultural setting, duration of symptoms, and presence of distress. Regarding duration of symptoms, there are striking differences in prevalence estimates between short-term and persistent problems related to lack of sexual interest. When distress about sexual functioning is required, prevalence estimates are markedly lower. Some older women report less distress about low sexual desire than younger women, although sexual desire may decrease with age.

Development and Course

By definition, lifelong female sexual interest/arousal disorder suggests that the lack of sexual interest or arousal has been present for the woman's entire sexual life. For Criteria A3, A4, and A6, which assess functioning during sexual activity, a subtype of lifelong would mean presence of symptoms since the individual's first sexual experiences. The acquired subtype would be assigned if the difficulties with sexual interest or arousal developed after a period of nonproblematic sexual functioning. Adaptive and normative changes in sexual functioning may result from partner-related, interpersonal, or personal events and may be transient in nature. However, persistence of symptoms for approximately 6 months or more would constitute a sexual dysfunction.

There are normative changes in sexual interest and arousal across the life span. Furthermore, women in relationships of longer duration are more likely to report engaging in sex despite no obvious feelings of sexual desire at the outset of a sexual encounter compared with women in shorter-duration relationships. Vaginal dryness in older women is related to age and menopausal status.

Risk and Prognostic Factors

Temperamental. Temperamental factors include negative cognitions and attitudes about sexuality and past history of mental disorders. Differences in propensity for sexual excitation and sexual inhibition may also predict the likelihood of developing sexual problems.

Environmental. Environmental factors include relationship difficulties, partner sexual functioning, and developmental history, such as early relationships with caregivers and childhood stressors.

Genetic and physiological. Some medical conditions (e.g., diabetes mellitus, thyroid dysfunction) can be risk factors for female sexual interest/arousal disorder. There appears to be a strong influence of genetic factors on vulnerability to sexual problems in women. Psychophysiological research using vaginal photoplethysmography has not found differences between women with and without perceived lack of genital arousal.

Culture-Related Diagnostic Issues

There is marked variability in prevalence rates of low desire across cultures. Lower rates of sexual desire may be more common among East Asian women compared with Euro-Canadian women. Although the lower levels of sexual desire and arousal found in men and women from East Asian countries compared with Euro-American groups may reflect less interest in sex in those cultures, the possibility remains that such group differences are an artifact of the measures used to quantify desire. A judgment about whether low sexual

desire reported by a woman from a certain ethnocultural group meets criteria for female sexual interest/arousal disorder must take into account the fact that different cultures may pathologize some behaviors and not others.

Gender-Related Diagnostic Issues

By definition, the diagnosis of female sexual interest/arousal disorder is only given to women. Distressing difficulties with sexual desire in men would be considered under male hypoactive sexual desire disorder.

Functional Consequences of Female Sexual Interest/Arousal Disorder

Difficulties in sexual interest/arousal are often associated with decreased relationship satisfaction.

Differential Diagnosis

Nonsexual mental disorders. Nonsexual mental disorders, such as major depressive disorder, in which there is "markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day," may explain the lack of sexual interest/arousal. If the lack of interest or arousal is completely attributable to another mental disorder, then a diagnosis of female sexual interest/arousal disorder would not be made.

Substance/medication use. Substance or medication use may explain the lack of interest/arousal.

Another medical condition. If the sexual symptoms are considered to be almost exclusively associated with the effects of another medical condition (e.g., diabetes mellitus, endothelial disease, thyroid dysfunction, central nervous system disease), then a diagnosis of female sexual interest/arousal disorder would not be made.

Interpersonal factors. If interpersonal or significant contextual factors, such as severe relationship distress, intimate partner violence, or other significant stressors, explain the sexual interest/arousal symptoms, then a diagnosis of female sexual interest/arousal disorder would not be made.

Other sexual dysfunctions. The presence of another sexual dysfunction does not rule out a diagnosis of female sexual interest/arousal disorder. It is common for women to experience more than one sexual dysfunction. For example, the presence of chronic genital pain may lead to a lack of desire for the (painful) sexual activity. Lack of interest and arousal during sexual activity may impair orgasmic ability. For some women, all aspects of the sexual response may be unsatisfying and distressing.

Inadequate or absent sexual stimuli. When differential diagnoses are being considered, it is important to assess the adequacy of sexual stimuli within the woman's sexual experience. In cases where inadequate or absent sexual stimuli are contributing to the clinical picture, there may be evidence for clinical care, but a sexual dysfunction diagnosis would not be made. Similarly, transient and adaptive alterations in sexual functioning that are secondary to a significant life or personal event must be considered in the differential diagnosis.

Comorbidity

Comorbidity between sexual interest/arousal problems and other sexual difficulties is extremely common. Sexual distress and dissatisfaction with sex life are also highly correlated in women with low sexual desire. Distressing low desire is associated with depression, thyroid problems, anxiety, urinary incontinence, and other medical factors. Arthritis and inflammatory or irritable bowel disease are also associated with sexual arousal prob-

lems. Low desire appears to be comorbid with depression, sexual and physical abuse in adulthood, global mental functioning, and use of alcohol.

Genito-Pelvic Pain/Penetration Disorder

Diagnostic Criteria **302.76 (F52.6)**

A. Persistent or recurrent difficulties with one (or more) of the following:
   1. Vaginal penetration during intercourse.
   2. Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts.
   3. Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration.
   4. Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of a severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.

Acquired: The disturbance began after a period of relatively normal sexual function.

Specify current severity:

Mild: Evidence of mild distress over the symptoms in Criterion A.

Moderate: Evidence of moderate distress over the symptoms in Criterion A.

Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

Genito-pelvic pain/penetration disorder refers to four commonly comorbid symptom dimensions: 1) difficulty having intercourse, 2) genito-pelvic pain, 3) fear of pain or vaginal penetration, and 4) tension of the pelvic floor muscles (Criterion A). Because major difficulty in any one of these symptom dimensions is often sufficient to cause clinically significant distress, a diagnosis can be made on the basis of marked difficulty in only one symptom dimension. However, all four symptom dimensions should be assessed even if a diagnosis can be made on the basis of only one symptom dimension.

Marked difficulty having vaginal intercourse/penetration (Criterion A1) can vary from a total inability to experience vaginal penetration in any situation (e.g., intercourse, gynecological examinations, tampon insertion) to the ability to easily experience penetration in one situation and but not in another. Although the most common clinical situation is when a woman is unable to experience intercourse or penetration with a partner, difficulties in undergoing required gynecological examinations may also be present. *Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts* (Criterion A2) refers to pain occurring in different locations in the genito-pelvic area. Location of pain as well as intensity should be assessed. Typically, pain can be characterized as superficial (vulvovaginal or occurring during penetration) or deep (pelvic; i.e., not felt until deeper penetration). The intensity of the pain is often not linearly related to distress or interference with sexual intercourse or other sexual activities. Some genito-pelvic pain only occurs when provoked (i.e., by intercourse or mechanical stim-

ulation); other genito-pelvic pain may be spontaneous as well as provoked. Genito-pelvic pain can also be usefully characterized qualitatively (e.g., "burning," "cutting," "shooting," "throbbing"). The pain may persist for a period after intercourse is completed and may also occur during urination. Typically, the pain experienced during sexual intercourse can be reproduced during a gynecological examination.

Marked fear or anxiety about vulvovaginal or pelvic pain either in anticipation of, or during, or as a result of vaginal penetration (Criterion A3) is commonly reported by women who have regularly experienced pain during sexual intercourse. This "normal" reaction may lead to avoidance of sexual/intimate situations. In other cases, this marked fear does not appear to be closely related to the experience of pain but nonetheless leads to avoidance of intercourse and vaginal penetration situations. Some have described this as similar to a phobic reaction except that the phobic object may be vaginal penetration or the fear of pain.

Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration (Criterion A4) can vary from reflexive-like spasm of the pelvic floor in response to attempted vaginal entry to "normal/voluntary" muscle guarding in response to the anticipated or the repeated experience of pain or to fear or anxiety. In the case of "normal/guarding" reactions, penetration may be possible under circumstances of relaxation. The characterization and assessment of pelvic floor dysfunction is often best undertaken by a specialist gynecologist or by a pelvic floor physical therapist.

Associated Features Supporting Diagnosis

Genito-pelvic pain/penetration disorder is frequently associated with other sexual dysfunctions, particularly reduced sexual desire and interest (female sexual interest/arousal disorder). Sometimes desire and interest are preserved in sexual situations that are not painful or do not require penetration. Even when individuals with genito-pelvic pain/penetration disorder report sexual interest/motivation, there is often behavioral avoidance of sexual situations and opportunities. Avoidance of gynecological examinations despite medical recommendations is also frequent. The pattern of avoidance is similar to that seen in phobic disorders. It is common for women who have not succeeded in having sexual intercourse to come for treatment only when they wish to conceive. Many women with genito-pelvic pain/penetration disorder will experience associated relationship/marital problems; they also often report that the symptoms significantly diminish their feelings of femininity.

In addition to the subtype "lifelong/acquired," five factors should be considered during assessment and diagnosis of genito-pelvic pain/penetration disorder because they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's 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/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different women with this disorder.

There are no valid physiological measures of any of the component symptom dimensions of genito-pelvic pain/penetration disorder. Validated psychometric inventories may be used to formally assess the pain and anxiety components related to genito-pelvic pain/penetration disorder.

Prevalence

The prevalence of genito-pelvic pain/penetration disorder is unknown. However, approximately 15% of women in North America report recurrent pain during intercourse. Difficulties having intercourse appear to be a frequent referral to sexual dysfunction clinics and to specialist clinicians.

Development and Course

The development and course of genito-pelvic pain/penetration disorder is unclear. Because women generally do not seek treatment until they experience problems in sexual functioning, it can, in general, be difficult to characterize genito-pelvic pain/penetration disorder as lifelong (primary) or acquired (secondary). Although women typically come to clinical attention after the initiation of sexual activity, there are often earlier clinical signs. For example, difficulty with or the avoidance of use of tampons is an important predictor of later problems. Difficulties with vaginal penetration (inability or fear or pain) may not be obvious until sexual intercourse is attempted. Even once intercourse is attempted, the frequency of attempts may not be significant or regular. In cases where it is difficult to establish whether symptomatology is lifelong or acquired, it is useful to determine the presence of any consistent period of successful pain-, fear-, and tension-free intercourse. If the experience of such a period can be established, then genito-pelvic pain/penetration disorder can be characterized as acquired. Once symptomatology is well established for a period of approximately 6 months, the probability of spontaneous and significant symptomatic remission appears to diminish.

Complaints related to genito-pelvic pain peak during early adulthood and in the peri- and postmenopausal period. Women with complaints about difficulty having intercourse appear to be primarily premenopausal. There may also be an increase in genito-pelvic pain–related symptoms in the postpartum period.

Risk and Prognostic Factors

Environmental. Sexual and/or physical abuse have often been cited as predictors of the DSM-IV-defined sexual pain disorders dyspareunia and vaginismus. This is a matter of controversy in the current literature.

Genetic and physiological. Women experiencing superficial pain during sexual intercourse often report the onset of the pain after a history of vaginal infections. Even after the infections have resolved and there are no known residual physical findings, the pain persists. Pain during tampon insertion or the inability to insert tampons before any sexual contact has been attempted is an important risk factor for genito-pelvic pain/penetration disorder.

Culture-Related Diagnostic Issues

In the past, inadequate sexual education and religious orthodoxy have often been considered to be culturally related predisposing factors to the DSM-IV diagnosis of vaginismus. This perception appears to be confirmed by recent reports from Turkey, a primarily Muslim country, indicating a strikingly high prevalence for the disorder. However, most available research, although limited in scope, does not support this notion (Lahaie et al. 2010).

Gender-Related Diagnostic Issues

By definition, the diagnosis of genito-pelvic pain/penetration disorder is only given to women. There is relatively new research concerning urological chronic pelvic pain syndrome in men, suggesting that men may experience some similar problems. The research and clinical experience are not sufficiently developed yet to justify the application of this diagnosis to men. Other specified sexual dysfunction or unspecified sexual dysfunction may be diagnosed in men appearing to fit this pattern.

Functional Consequences of Genito-Pelvic Pain/Penetration Disorder

Functional difficulties in genito-pelvic pain/penetration disorder are often associated with interference in relationship satisfaction and sometimes with the ability to conceive via penile/vaginal intercourse.

Differential Diagnosis

Another medical condition. In many instances, women with genito-pelvic pain/penetration disorder will also be diagnosed with another medical condition (e.g., lichen sclerosus, endometriosis, pelvic inflammatory disease, vulvovaginal atrophy). In some cases, treating the medical condition may alleviate the genito-pelvic pain/penetration disorder. Much of the time, this is not the case. There are no reliable tools or diagnostic methods to allow clinicians to know whether the medical condition or genito-pelvic pain/penetration disorder is primary. Often, the associated medical conditions are difficult to diagnose and treat. For example, the increased incidence of postmenopausal pain during intercourse may sometimes be attributable to vaginal dryness or vulvovaginal atrophy associated with declining estrogen levels. The relationship, however, between vulvovaginal atrophy/dryness, estrogen, and pain is not well understood.

Somatic symptom and related disorders. Some women with genito-pelvic pain/penetration disorder may also be diagnosable with somatic symptom disorder. Since both genito-pelvic pain/penetration disorder and the somatic symptom and related disorders are new diagnoses, it is not yet clear whether they can be reliably differentiated. Some women diagnosed with genito-pelvic pain/penetration disorder will also be diagnosed with a specific phobia.

Inadequate sexual stimuli. It is important that the clinician, in considering differential diagnoses, assess the adequacy of sexual stimuli within the woman's sexual experience. Sexual situations in which there is inadequate foreplay or arousal may lead to difficulties in penetration, pain, or avoidance. Erectile dysfunction or premature ejaculation in the male partner may result in difficulties with penetration. These conditions should be carefully assessed. In some situations, a diagnosis of genito-pelvic pain/penetration disorder may not be appropriate.

Comorbidity

Comorbidity between genito-pelvic pain/penetration disorder and other sexual difficulties appears to be common. Comorbidity with relationship distress is also common. This is not surprising, since in Western cultures the inability to have (pain-free) intercourse with a desired partner and the avoidance of sexual opportunities may be either a contributing factor to or the result of other sexual or relationship problems. Because pelvic floor symptoms are implicated in the diagnosis of genito-pelvic pain/penetration disorder, there is likely to be a higher prevalence of other disorders related to the pelvic floor or reproductive organs (e.g., interstitial cystitis, constipation, vaginal infection, endometriosis, irritable bowel syndrome).

Male Hypoactive Sexual Desire Disorder

Diagnostic Criteria **302.71 (F52.0)**

A. Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and general and sociocultural contexts of the individual's life.

B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.

C. The symptoms in Criterion A cause clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to thes effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.

Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:

Generalized: Not limited to certain types of stimulation, situations, or partners.

Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify current severity:

Mild: Evidence of mild distress over the symptoms in Criterion A.

Moderate: Evidence of moderate distress over the symptoms in Criterion A.

Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

When an assessment for male hypoactive sexual desire disorder is being made, interpersonal context must be taken into account. A "desire discrepancy," in which a man has lower desire for sexual activity than his partner, is not sufficient to diagnose male hypoactive sexual desire disorder. Both low/absent desire for sex and deficient/absent sexual thoughts or fantasies are required for a diagnosis of the disorder. There may be variation across men in how sexual desire is expressed.

The lack of desire for sex and deficient/absent erotic thoughts or fantasies must be persistent or recurrent and must occur for a minimum duration of approximately 6 months. The inclusion of this duration criterion is meant to safeguard against making a diagnosis in cases in which a man's low sexual desire may represent an adaptive response to adverse life conditions (e.g., concern about a partner's pregnancy when the man is considering terminating the relationship). The introduction of "approximately" in Criterion B allows for clinician judgment in cases in which symptom duration does not meet the recommended 6-month threshold.

Associated Features Supporting Diagnosis

Male hypoactive sexual desire disorder is sometimes associated with erectile and/or ejaculatory concerns. For example, persistent difficulties obtaining an erection may lead a man to lose interest in sexual activity. Men with hypoactive sexual desire disorder often report that they no longer initiate sexual activity and that they are minimally receptive to a partner's attempt to initiate. Sexual activities (e.g., masturbation or partnered sexual activity) may sometimes occur even in the presence of low sexual desire. Relationship-specific preferences regarding patterns of sexual initiation must be taken into account when making a diagnosis of male hypoactive sexual desire disorder. Although men are more likely to initiate sexual activity, and thus low desire may be characterized by a pattern of non-initiation, many men may prefer to have their partner initiate sexual activity. In such situations, the man's lack of receptivity to a partner's initiation should be considered when evaluating low desire.

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of male hypoactive sexual desire disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's 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/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treat-

ment. Each of these factors may contribute differently to the presenting symptoms of different men with this disorder.

Prevalence

The prevalence of male hypoactive sexual desire disorder varies depending on country of origin and method of assessment. Approximately 6% of younger men (ages 18–24 years) and 41% of older men (ages 66–74 years) have problems with sexual desire. However, a persistent lack of interest in sex, lasting 6 months or more, affects only a small proportion of men ages 16–44 (1.8%).

Development and Course

By definition, lifelong male hypoactive sexual desire disorder indicates that low or no sexual desire has always been present, whereas the acquired subtype would be assigned if the man's low desire developed after a period of normal sexual desire. There is a requirement that low desire persist for approximately 6 months or more; thus, short-term changes in sexual desire should not be diagnosed as male hypoactive sexual desire disorder.

There is a normative age-related decline in sexual desire. Like women, men identify a variety of triggers for their sexual desire, and they describe a wide range of reasons that they choose to engage in sexual activity. Although erotic visual cues may be more potent elicitors of desire in younger men, the potency of sexual cues may decrease with age and must be considered when evaluating men for hypoactive sexual desire disorder.

Risk and Prognostic Factors

Temperamental. Mood and anxiety symptoms appear to be strong predictors of low desire in men. Up to half of men with a past history of psychiatric symptoms may have moderate or severe loss of desire, compared with only 15% of those without such a history. A man's feelings about himself, his perception of his partner's sexual desire toward him, feelings of being emotionally connected, and contextual variables may all negatively (as well as positively) affect sexual desire.

Environmental. Alcohol use may increase the occurrence of low desire. Among gay men, self-directed homophobia, interpersonal problems, attitudes, lack of adequate sex education, and trauma resulting from early life experiences must be taken into account in explaining the low desire. Social and cultural contextual factors should also be considered.

Genetic and physiological. Endocrine disorders such as hyperprolactinemia significantly affect sexual desire in men. Age is a significant risk factor for low desire in men. It is unclear whether or not men with low desire also have abnormally low levels of testosterone; however, among hypogonadal men, low desire is common. There also may be a critical threshold below which testosterone will affect sexual desire in men and above which there is little effect of testosterone on men's desire.

Culture-Related Diagnostic Issues

There is marked variability in prevalence rates of low desire across cultures, ranging from 12.5% in Northern European men to 28% in Southeast Asian men ages 40–80 years. Just as there are higher rates of low desire among East Asian subgroups of women, men of East Asian ancestry also have higher rates of low desire. Guilt about sex may mediate this association between East Asian ethnicity and sexual desire in men.

Gender-Related Diagnostic Issues

In contrast to the classification of sexual disorders in women, desire and arousal disorders have been retained as separate constructs in men. Despite some similarities in the experi-

ence of desire across men and women, and the fact that desire fluctuates over time and is dependent on contextual factors, men do report a significantly higher intensity and frequency of sexual desire compared with women.

Differential Diagnosis

Nonsexual mental disorders. Nonsexual mental disorders, such as major depressive disorder, which is characterized by "markedly diminished interest or pleasure in all, or almost all, activities," may explain the lack of sexual desire. If the lack of desire is better explained by another mental disorder, then a diagnosis of male hypoactive sexual desire disorder would not be made.

Substance/medication use. Substance/medication use may explain the lack of sexual desire.

Another medical condition. If the low/absent desire and deficient/absent erotic thoughts or fantasies are better explained by the effects of another medical condition (e.g., hypogonadism, diabetes mellitus, thyroid dysfunction, central nervous system disease), then a diagnosis of male hypoactive sexual desire disorder would not be made.

Interpersonal factors. If interpersonal or significant contextual factors, such as severe relationship distress or other significant stressors, are associated with the loss of desire in the man, then a diagnosis of male hypoactive sexual desire disorder would not be made.

Other sexual dysfunctions. The presence of another sexual dysfunction does not rule out a diagnosis of male hypoactive sexual desire disorder; there is some evidence that up to one-half of men with low sexual desire also have erectile difficulties, and slightly fewer may also have early ejaculation difficulties. If the man's low desire is explained by self-identification as an asexual, then a diagnosis of male hypoactive sexual desire disorder is not made.

Comorbidity

Depression and other mental disorders, as well as endocrinological factors, are often comorbid with male hypoactive sexual desire disorder.

Premature (Early) Ejaculation

Diagnostic Criteria **302.75 (F52.4)**

A. A persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it.

Note: Although the diagnosis of premature (early) ejaculation may be applied to individuals engaged in nonvaginal sexual activities, specific duration criteria have not been established for these activities.

B. The symptom in Criterion A must have been present for at least 6 months and must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts).

C. The symptom in Criterion A causes clinically significant distress in the individual.

D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:

Lifelong: The disturbance has been present since the individual became sexually active.

Acquired: The disturbance began after a period of relatively normal sexual function.

Specify whether:

Generalized: Not limited to certain types of stimulation, situations, or partners.

Situational: Only occurs with certain types of stimulation, situations, or partners.

Specify current severity:

Mild: Ejaculation occurring within approximately 30 seconds to 1 minute of vaginal penetration.

Moderate: Ejaculation occurring within approximately 15–30 seconds of vaginal penetration.

Severe: Ejaculation occurring prior to sexual activity, at the start of sexual activity, or within approximately 15 seconds of vaginal penetration.

Diagnostic Features

Premature (early) ejaculation is manifested by ejaculation that occurs prior to or shortly after vaginal penetration, operationalized by an individual's estimate of ejaculatory latency (i.e., elapsed time before ejaculation) after vaginal penetration. Estimated and measured intravaginal ejaculatory latencies are highly correlated as long as the ejaculatory latency is of short duration; therefore, self-reported estimates of ejaculatory latency are sufficient for diagnostic purposes. A 60-second intravaginal ejaculatory latency time is an appropriate cutoff for the diagnosis of lifelong premature (early) ejaculation in heterosexual men. There are insufficient data to determine if this duration criterion can be applied to acquired premature (early) ejaculation. The durational definition may apply to males of varying sexual orientations, since ejaculatory latencies appear to be similar across men of different sexual orientations and across different sexual activities.

Associated Features Supporting Diagnosis

Many males with premature (early) ejaculation complain of a sense of lack of control over ejaculation and report apprehension about their anticipated inability to delay ejaculation on future sexual encounters.

The following factors may be relevant in the evaluation of any sexual dysfunction: 1) partner factors (e.g., partner's sexual problems, partner's 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), and stressors (e.g., job loss, bereavement); 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment.

Prevalence

Estimates of the prevalence of premature (early) ejaculation vary widely depending on the definition utilized. Internationally, more than 20%–30% of men ages 18–70 years report concern about how rapidly they ejaculate. With the new definition of premature (early) ejaculation (i.e., ejaculation occurring within approximately 1 minute of vaginal penetration), only 1%–3% of men would be diagnosed with the disorder. Prevalence of premature (early) ejaculation may increase with age.

Development and Course

By definition, lifelong premature (early) ejaculation starts during a male's initial sexual experiences and persists thereafter. Some men may experience premature (early) ejaculation during their initial sexual encounters but gain ejaculatory control over time. It is the persistence of ejaculatory problems for longer than 6 months that determines the diagnosis of premature (early) ejaculation. In contrast, some men develop the disorder after a period of

having a normal ejaculatory latency, known as *acquired premature (early) ejaculation.* There is far less known about acquired premature (early) ejaculation than about lifelong premature (early) ejaculation. The acquired form likely has a later onset, usually appearing during or after the fourth decade of life. Lifelong is relatively stable throughout life. Little is known about the course of acquired premature (early) ejaculation. Reversal of medical conditions such as hyperthyroidism and prostatitis appears to restore ejaculatory latencies to baseline values. Lifelong premature (early) ejaculation begins with early sexual experiences and persists throughout an individual's life. In approximately 20% of men with premature (early) ejaculation, ejaculatory latencies decrease further with age. Age and relationship length have been found to be negatively associated with prevalence of premature (early) ejaculation.

Risk and Prognostic Factors

Temperamental. Premature (early) ejaculation may be more common in men with anxiety disorders, especially social anxiety disorder (social phobia).

Genetic and physiological. There is a moderate genetic contribution to lifelong premature (early) ejaculation. Premature (early) ejaculation may be associated with dopamine transporter gene polymorphism or serotonin transporter gene polymorphism. Thyroid disease, prostatitis, and drug withdrawal are associated with acquired premature (early) ejaculation. Positron emission tomography measures of regional cerebral blood flow during ejaculation have shown primary activation in the mesocephalic transition zone, including the ventral tegmental area.

Culture-Related Diagnostic Issues

Perception of what constitutes a normal ejaculatory latency is different in many cultures. Measured ejaculatory latencies may differ in some countries. Such differences may be explained by cultural or religious factors as well as genetic differences between populations.

Gender-Related Diagnostic Issues

Premature (early) ejaculation is a sexual disorder in males. Males and their sexual partners may differ in their perception of what constitutes an acceptable ejaculatory latency. There may be increasing concerns in females about early ejaculation in their sexual partners, which may be a reflection of changing societal attitudes concerning female sexual activity.

Diagnostic Markers

Ejaculatory latency is usually monitored in research settings by the sexual partner utilizing a timing device (e.g., stopwatch), though this is not ideal in real-life sexual situations. For vaginal intercourse, the time between intravaginal penetration and ejaculation is measured.

Functional Consequences of Premature (Early) Ejaculation

A pattern of premature (early) ejaculation may be associated with decreased self-esteem, a sense of lack of control, and adverse consequences for partner relationships. It may also cause personal distress in the sexual partner and decreased sexual satisfaction in the sexual partner. Ejaculation prior to penetration may be associated with difficulties in conception.

Differential Diagnosis

Substance/medication-induced sexual dysfunction. When problems with premature ejaculation are due exclusively to substance use, intoxication, or withdrawal, substance/medication-induced sexual dysfunction should be diagnosed.

Ejaculatory concerns that do not meet diagnostic criteria. It is necessary to identify males with normal ejaculatory latencies who desire longer ejaculatory latencies and males who have episodic premature (early) ejaculation (e.g., during the first sexual encounter with a new partner when a short ejaculatory latency may be common or normative). Neither of these situations would lead to a diagnosis of premature (early) ejaculation, even though these situations may be distressing to some males.

Comorbidity

Premature (early) ejaculation may be associated with erectile problems. In many cases, it may be difficult to determine which difficulty preceded the other. Lifelong premature (early) ejaculation may be associated with certain anxiety disorders. Acquired premature (early) ejaculation may be associated with prostatitis, thyroid disease, or drug withdrawal (e.g., during opioid withdrawal).

Substance/Medication-Induced Sexual Dysfunction

Diagnostic Criteria

A. A clinically significant disturbance in sexual function is predominant in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

   1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
   2. The involved substance/medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by a sexual dysfunction that is not substance/medication-induced. Such evidence of an independent sexual dysfunction could include the following:

   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced sexual dysfunction (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress in the individual.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced sexual dysfunctions are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced sexual dysfunction, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced sexual dysfunction (e.g., "mild cocaine use disorder with cocaine-induced sexual dysfunction"). If a moderate or severe substance use disorder is comorbid with the substance-induced sexual dysfunction, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance

use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced sexual dysfunction.

		ICD-10-CM		
	ICD-9-CM	With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Alcohol	291.89	F10.181	F10.281	F10.981
Opioid	292.89	F11.181	F11.281	F11.981
Sedative, hypnotic, or anxiolytic	292.89	F13.181	F13.281	F13.981
Amphetamine (or other stimulant)	292.89	F15.181	F15.281	F15.981
Cocaine	292.89	F14.181	F14.281	F14.981
Other (or unknown) substance	292.89	F19.181	F19.281	F19.981

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

With onset after medication use: Symptoms may appear either at initiation of medication or after a modification or change in use.

Specify current severity:

Mild: Occurs on 25%–50% of occasions of sexual activity.

Moderate: Occurs on 50%–75% of occasions of sexual activity.

Severe: Occurs on 75% or more of occasions of sexual activity.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced sexual dysfunction begins with the specific substance (e.g., alcohol, fluoxetine) that is presumed to be causing the sexual dysfunction. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes (e.g., fluoxetine), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use), followed by the severity specifier (e.g., mild, moderate, severe). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of erectile dysfunction occurring during intoxication in a man with a severe alcohol use disorder, the diagnosis is 291.89 alcohol-induced sexual dysfunction, with onset during intoxication, moderate. An additional diagnosis of 303.90 severe alcohol use disorder is also given. When more than one substance is judged to play a sig-

nificant role in the development of the sexual dysfunction, each should be listed separately (e.g., 292.89 cocaine-induced sexual dysfunction with onset during intoxication, moderate; 292.89 fluoxetine-induced sexual dysfunction, with onset after medication use).

ICD-10-CM. The name of the substance/medication-induced sexual dysfunction begins with the specific substance (e.g., alcohol, fluoxetine) that is presumed to be causing the sexual dysfunction. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., fluoxetine), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word "with," followed by the name of the substance-induced sexual dysfunction, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use), followed by the severity specifier (e.g., mild, moderate, severe). For example, in the case of erectile dysfunction occurring during intoxication in a man with a severe alcohol use disorder, the diagnosis is F10.281 moderate alcohol use disorder with alcohol-induced sexual dysfunction, with onset during intoxication, moderate. A separate diagnosis of the comorbid severe alcohol use disorder is not given. If the substance-induced sexual dysfunction occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F15.981 amphetamine-induced sexual dysfunction, with onset during intoxication). When more than one substance is judged to play a significant role in the development of the sexual dysfunction, each should be listed separately (e.g., F14.181 mild cocaine use disorder with cocaine-induced sexual dysfunction, with onset during intoxication, moderate; F19.981 fluoxetine-induced sexual dysfunction, with onset after medication use, moderate).

Diagnostic Features

The major feature is a disturbance in sexual function that has a temporal relationship with substance/medication initiation, dose increase, or substance/medication discontinuation.

Associated Features Supporting Diagnosis

Sexual dysfunctions can occur in association with intoxication with the following classes of substances: alcohol; opioids; sedatives, hypnotics, or anxiolytics; stimulants (including cocaine); and other (or unknown) substances. Sexual dysfunctions can occur in association with withdrawal from the following classes of substances: alcohol; opioids; sedatives, hypnotics, or anxiolytics; and other (or unknown) substances. Medications that can induce sexual dysfunctions include antidepressants, antipsychotics, and hormonal contraceptives.

The most commonly reported side effect of antidepressant drugs is difficulty with orgasm or ejaculation. Problems with desire and erection are less frequent. Approximately 30% of sexual complaints are clinically significant. Certain agents, such as bupropion and mirtazapine, appear not to be associated with sexual side effects.

The sexual problems associated with antipsychotic drugs, including problems with sexual desire, erection, lubrication, ejaculation, or orgasm, have occurred with typical as well as atypical agents. However, problems are less common with prolactin-sparing antipsychotics than with agents that cause significant prolactin elevation.

Although the effects of mood stabilizers on sexual function are unclear, it is possible that lithium and anticonvulsants, with the possible exception of lamotrigine, have adverse effects on sexual desire. Problems with orgasm may occur with gabapentin. Similarly, there may be a higher prevalence of erectile and orgasmic problems associated with benzodiazepines. There have not been such reports with buspirone.

Many nonpsychiatric medications, such as cardiovascular, cytotoxic, gastrointestinal, and hormonal agents, are associated with disturbances in sexual function. Illicit substance use is associated with decreased sexual desire, erectile dysfunction, and difficulty reaching orgasm. Sexual dysfunctions are also seen in individuals receiving methadone but are seldom reported by patients receiving buprenorphine. Chronic alcohol abuse and chronic nicotine abuse are associated with erectile problems.

Prevalence

The prevalence and the incidence of substance/medication-induced sexual dysfunction are unclear, likely because of underreporting of treatment-emergent sexual side effects. Data on substance/medication-induced sexual dysfunction typically concern the effects of antidepressant drugs. The prevalence of antidepressant-induced sexual dysfunction varies in part depending on the specific agent. Approximately 25%–80% of individuals taking monoamine oxidase inhibitors, tricyclic antidepressants, serotonergic antidepressants, and combined serotonergic-adrenergic antidepressants report sexual side effects. There are differences in the incidence of sexual side effects between some serotonergic and combined adrenergic-serotonergic antidepressants, although it is unclear if these differences are clinically significant.

Approximately 50% of individuals taking antipsychotic medications will experience adverse sexual side effects, including problems with sexual desire, erection, lubrication, ejaculation, or orgasm. The incidence of these side effects among different antipsychotic agents is unclear.

Exact prevalence and incidence of sexual dysfunctions among users of nonpsychiatric medications such as cardiovascular, cytotoxic, gastrointestinal, and hormonal agents are unknown. Elevated rates of sexual dysfunction have been reported with methadone or high-dose opioid drugs for pain. There are increased rates of decreased sexual desire, erectile dysfunction, and difficulty reaching orgasm associated with illicit substance use. The prevalence of sexual problems appears related to chronic drug abuse and appears higher in individuals who abuse heroin (approximately 60%–70%) than in individuals who abuse amphetamines or 3,4-methylenedioxymethamphetamine (i.e., MDMA, ecstasy). Elevated rates of sexual dysfunction are also seen in individuals receiving methadone but are seldom reported by patients receiving buprenorphine. Chronic alcohol abuse and chronic nicotine abuse are related to higher rates of erectile problems.

Development and Course

The onset of antidepressant-induced sexual dysfunction may be as early as 8 days after the agent is first taken. Approximately 30% of individuals with mild to moderate orgasm delay will experience spontaneous remission of the dysfunction within 6 months. In some cases, serotonin reuptake inhibitor–induced sexual dysfunction may persist after the agent is discontinued. The time to onset of sexual dysfunction after initiation of antipsychotic drugs or drugs of abuse is unknown. It is probable that the adverse effects of nicotine and alcohol may not appear until after years of use. Premature (early) ejaculation can sometimes occur after cessation of opioid use. There is some evidence that disturbances in sexual function related to substance/medication use increase with age.

Culture-Related Diagnostic Issues

There may be an interaction among cultural factors, the influence of medications on sexual functioning, and the response of the individual to those changes.

Gender-Related Diagnostic Issues

Some gender differences in sexual side effects may exist.

Functional Consequences of Substance/Medication-Induced Sexual Dysfunction

Medication-induced sexual dysfunction may result in medication noncompliance.

Differential Diagnosis

Non-substance/medication-induced sexual dysfunctions. Many mental conditions, such as depressive, bipolar, anxiety, and psychotic disorders, are associated with disturbances of sexual function. Thus, differentiating a substance/medication-induced sexual dysfunction from a manifestation of the underlying mental disorder can be quite difficult. The diagnosis is usually established if a close relationship between substance/medication initiation or discontinuation is observed. A clear diagnosis can be established if the problem occurs after substance/medication initiation, dissipates with substance/medication discontinuation, and recurs with introduction of the same agent. Most substance/medication-induced side effects occur shortly after initiation or discontinuation. Sexual side effects that only occur after chronic use of a substance/medication may be extremely difficult to diagnose with certainty.

Other Specified Sexual Dysfunction

302.79 (F52.8)

This category applies to presentations in which symptoms characteristic of a sexual dysfunction that cause clinically significant distress in the individual predominate but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. The other specified sexual dysfunction category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific sexual dysfunction. This is done by recording "other specified sexual dysfunction" followed by the specific reason (e.g., "sexual aversion").

Unspecified Sexual Dysfunction

302.70 (F52.9)

This category applies to presentations in which symptoms characteristic of a sexual dysfunction that cause clinically significant distress in the individual predominate but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. The unspecified sexual dysfunction category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific sexual dysfunction, and includes presentations for which there is insufficient information to make a more specific diagnosis.