

13 - Sexual Dysfunctions

Sexual Dysfunctions

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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 dysfunctions 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 or treatment and 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 and relationship duration 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

F52.32 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. The population of gender-diverse persons, including transgender, nonbinary, and agender, may not identify with or appear to fit into the existing sex- and gender-based diagnostic categories described in this chapter. Despite the names given to male hypoactive sexual desire disorder and female sexual interest arousal disorder, the diagnostic criteria describe symptoms and experiences that are not dependent on the individual's specific sex or gender. As such, either diagnosis can be applied to gender-diverse individuals based on clinical judgment. For diagnoses linked to reproductive anatomy (e.g., erectile dysfunction, premature [early] ejaculation, delayed ejaculation, and genito-pelvic pain/penetration disorder), diagnoses should be based on the individual's current anatomy and not on the individual's sex assigned at birth. Much more research is needed to understand experiences of sexual dysfunction among gender-diverse persons. In the meantime, as with all categories in DSM, clinicians should use their best judgment. If the sexual dysfunction is mostly explainable by another nonsexual mental disorder (e.g., depressive or bipolar disorder, anxiety disorder, posttraumatic stress disorder, psychotic disorder), 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 person 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 Z code for the relationship problem or stressor may be listed (e.g., Z63.0 Relationship distress with spouse or intimate partner); see the chapter "Other Conditions That May Be a Focus of Clinical Attention." In many cases, a precise etiological relationship between another condition (e.g., a medical condition) and a sexual dysfunction cannot be established. It is possible to have a diagnosis of a sexual dysfunction and a coexisting medical condition, nonsexual mental disorder, or use/misuse or discontinuation of a drug or substance; and it is possible to have one or more diagnoses of sexual dysfunction. Delayed Ejaculation Diagnostic Criteria 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 essential feature of delayed ejaculation is a marked delay in or inability to achieve ejaculation or marked infrequency of ejaculation on all or almost all occasions of partnered sexual activity, despite the presence of adequate sexual stimulation and the desire to ejaculate (Criterion A). In order to qualify for a DSM-5 diagnosis of delayed ejaculation, the symptoms must have persisted for a minimum duration of approximately 6 months (Criterion B) and must cause clinically significant distress in the individual (Criterion C). The partnered sexual activity may include manual, oral, coital, or anal stimulation. In most cases, the diagnosis will be made by self-report, although for men in heterosexual partnered relationships, it is frequently the female partner's distress that motivates treatment seeking. It is common for men who present with delayed ejaculation to be able to ejaculate with self-stimulation, but not during partnered sexual activity. The definition of "delay" does not have precise boundaries, as there is no consensus as to what constitutes a reasonable time to reach orgasm or what is unacceptably long for most men and their sexual partners. Although the definitions of delayed ejaculation apply equally well to

both heterosexual and homosexual orientation, the vast majority of the research focus has been based on the concept of intravaginal latency, and therefore male-female intercourse. The findings from those studies document that the majority of men's intravaginal ejaculatory latency time (IELT) range is approximately 4–10 minutes. There is also no clear diagnostic delineation between delayed ejaculation as a sexual dysfunction and delay that is a consequence of normal aging. Therefore, the diagnosis of delayed ejaculation is based on clinical judgment, taking into consideration the individual's psychosexual and medical history, age, relationship context, and sexual stimulation patterns and behaviors. The diagnosis of delayed ejaculation should not be given if the clinician judges that the individual's dissatisfaction is entirely attributable to unrealistic expectations. Associated Features The man and his partner may report prolonged thrusting to achieve orgasm to the point of exhaustion or genital discomfort and sometimes even injury to himself and/or his partner before finally ceasing. Some males may report avoiding sexual activity because of a repetitive pattern of difficulty ejaculating. Delayed ejaculation is associated with highly frequent masturbation, use of masturbation techniques not easily duplicated by a partner, and marked disparities between sexual fantasies during masturbation and the reality of sex with a partner. Males with delayed ejaculation typically report less coital activity, higher levels of relationship distress, sexual dissatisfaction, lower subjective arousal, anxiety about their sexual performance, and general health issues than sexually functional men. In addition to considerations of applicable subtypes (i.e., whether the ejaculatory delay has been present since the individual became sexually active or began after a period of relatively normal sexual function, and whether the ejaculatory delay is generalized or occurs only with certain types of stimulation, situations, or partners), the following factors are important to consider in the assessment of delayed ejaculation: 1) partner factors (e.g., partner's sexual problems or health); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., hypoactive sexual desire), psychiatric comorbidity (e.g., depression, anxiety), or stressors such as job loss or stress; 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); 5) medical factors, particularly hypogonadism or neurological

disorders (e.g., multiple sclerosis, diabetic neuropathy); and 6) use of substances or medications that might inhibit ejaculation (e.g., use of serotonergic drugs). **Prevalence** The prevalence of delayed ejaculation in the United States is estimated at 1%–5% but has ranged as high as 11% in international studies. However, variation in syndrome definitions across studies may have contributed to differences in the prevalence of the DSM-5 disorder. **Development and Course**

Genetic and physiological. Another medical condition or injury and/or its treatment. Lifelong delayed ejaculation begins with early sexual experiences and continues throughout the course of an individual's life. Acquired delayed ejaculation begins after a period of normal sexual function. A number of biomedical, psychosocial, and cultural factors can contribute to the predisposition to or maintenance of lifelong or acquired delayed ejaculation (see the section "Risk and Prognostic Factors"), and either subtype can be generalized or situational in nature. The prevalence of delayed ejaculation increases with age. As males age, they are more likely to have progressively more of the following changes in ejaculatory function, including, but not limited to, reduced ejaculatory volume, force, and sensation, and increased "refractory time." Refractory latency increases for males secondary to surgical, medical, and pharmaceutical complications, as well as aging. **Risk and Prognostic Factors** Ejaculatory latency is an end point consequence that is determined by a range of factors. A large number of psychosocial factors increase the probability of an individual experiencing delayed ejaculation, with depression and relationship dissatisfaction being predominant contributors. Numerous medical conditions may lead to delayed ejaculation, including procedures that disrupt sympathetic or somatic innervation to the genital region such as radical prostatectomy for cancer treatment. Neurological and endocrine disorders, including spinal cord injury, stroke, multiple sclerosis, pelvic-region surgery, severe diabetes, epilepsy, hormonal abnormalities, and sleep apnea, as well as alcohol abuse, bowel dysfunction, cannabis use, and environmental factors, may be associated with delayed ejaculation. Additionally, medications that inhibit α -adrenergic innervation of the ejaculatory system (e.g., tamsulosin) are associated with delayed ejaculation, as well as antihypertensive agents, antidepressants (e.g., selective serotonin reuptake inhibitors), and antipsychotic drugs. Age-related loss of the fast-conducting peripheral sensory nerves and age-related decreased sex steroid secretion may be associated with an increase in delayed ejaculation in males as they age. Reduced androgen levels with age may also be associated with delayed ejaculation. **Sex- and Gender-Related Diagnostic Issues** By definition, the diagnosis of delayed ejaculation is only given to males. Distressing difficulties with orgasm in women would be considered under female orgasmic disorder. **Functional Consequences of Delayed Ejaculation** Delayed ejaculation is often associated with considerable psychological distress in one or both partners. Difficulty with ejaculation may contribute to difficulties in conception and lead to significant fertility assessment, as the lack of ejaculation is not often spontaneously discussed by individuals unless there is direct inquiry from their physician. **Differential Diagnosis** A major diagnostic challenge is

Substance/medication use. Dysfunction with orgasm. F52.21 differentiating between a delayed ejaculation that is fully explained by another medical condition or injury (or its treatment) and a delayed ejaculation attributable to a variety of proportionally different biomedical-psychosocial and cultural factors that determine the symptom(s). A number of medical conditions or injuries, along with their treatments, may produce delays in ejaculation independent of psychosocial and cultural issues. Delayed ejaculation must be differentiated from a number of urological conditions (especially other ejaculatory disorders), including retrograde ejaculation or anejaculation, which is

typically the result of etiologies ranging from hormonal to neurological and/or anatomical abnormalities, including ejaculatory duct obstruction and other urological disorders. A number of pharmacological agents, such as antidepressants, antipsychotics, α sympathetic drugs, alcohol, and opioid drugs, can cause ejaculatory problems. In such cases, the diagnosis is substance/medication-induced sexual dysfunction instead of delayed ejaculation. 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 male 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 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 a marked difficulty in obtaining or maintaining an erection or a marked decrease in erectile rigidity in all or almost all occasions of sexual activity (Criterion A) that has persisted for at least 6 months (Criterion B) and that causes clinically significant distress in the individual (Criterion C). 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. This chapter uses the terms erectile disorder and erectile dysfunction, which are not synonymous. Erectile dysfunction is a widely used descriptive term (including in ICD-10) that refers to difficulty getting and maintaining an erection. Erectile disorder is the more specific DSM-5 diagnostic category in which erectile dysfunction persists for at least 6 months and causes distress in the individual. Associated Features Many males with erectile disorder may have low self-esteem, low self-confidence, and a decreased sense of masculinity, and may experience depressed mood. Erectile dysfunction is also strongly associated with feelings of

guilt, self-blame, sense of failure, anger, and concern about disappointing one's partner. 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 considerations of applicable subtypes (i.e., whether the erectile dysfunction has

been present since the individual became sexually active or began after a period of relatively normal sexual function, and whether the erectile dysfunction is generalized or occurs only with certain types of stimulation, situations, or partners), the following factors are important to consider in the assessment of erectile disorder: 1) partner factors (e.g., partner's sexual problems or health); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., hypoactive sexual desire), psychiatric comorbidity (e.g., depression, anxiety), or stressors such as job loss or stress; 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); 5) medical factors, particularly surgery (e.g., transurethral resection of the prostate), hypogonadism, or neurological conditions (e.g., multiple sclerosis, diabetic neuropathy); and 6) use of substances or medications that might inhibit ejaculation (e.g., use of serotonergic drugs). 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. Internationally, the prevalence of erectile disorder in the general population is approximately 13%–21% of males ages 40–80 years. Rates appear to be lower than 10% in males younger than 40 years, about 20%–40% in males in their 60s, and 50%–75% in males older than 70 years. In a longitudinal study in Australia, 80% of males age 70 and older experienced erectile disorder. In a review of studies largely from Western countries, about 20% of males feared erectile problems on their first sexual experience, whereas approximately 8% experienced erectile problems that hindered penetration during their first sexual experience. Among U.S.-based respondents to an online survey, there was no statistically significant difference in the prevalence of erectile disorder by ethnoracial background. Nationally representative U.S. data show that the prevalence of erectile difficulties is similar in older males who have sex with males or with both males and females. 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 evidence regarding the persistence of such problems after the first attempt. It is assumed that most of these problems spontaneously remit without professional intervention, but some males 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 males diagnosed as having moderate erectile failure

Course modifiers. may experience spontaneous remission of symptoms without medical intervention. Distress associated with erectile disorder is lower in older males as compared with younger males. Risk and Prognostic Factors Risk factors for acquired erectile dysfunction and, as a consequence, erectile disorder include age, smoking tobacco, lack of physical exercise, diabetes, and decreased desire. Culture-Related Diagnostic Issues Prevalence of erectile disorder varies

across countries. It is unclear to what extent these variations represent differences in cultural expectations as opposed to genuine differences in the frequency of erectile failure. Differential endorsement may be related to cultural concerns about appearing weak or less masculine or to diverse cultural norms about changes in erectile function during healthy aging. Cultural expectations concerning marital relationships, sexual performance, fertility, and gender roles can influence anxieties that may contribute to erectile disorder. Based on responses to an online survey, erectile disorder may be associated with concern about genital size in the United States and the Middle East and with fears of male infertility more frequently in the Middle East.

Sex- and Gender-Related Diagnostic Issues By definition, the diagnosis of erectile dysfunction is only given to males. Distressing difficulties with sexual arousal in women would be considered under female sexual interest/arousal disorder.

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. Testing for low levels of serum bioavailable or free testosterone is appropriate especially when diabetes is present, for men who also experience hypoactive desire, and for those who do not respond to phosphodiesterase type 5 inhibitors. 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 males 40 years and older is predictive of the future risk for coronary artery disease.

Association With Suicidal Thoughts or Behavior Among males receiving treatment for erectile disorder with comorbid depression, elevated rates

Nonsexual mental disorders. Normal erectile function. Substance/medication use. Another medical condition. of suicidal thoughts or behavior have been observed; while the affected males attributed the suicidal symptoms to their erectile disorder, the presence of depression was also a likely contributing factor. Elevated suicide rates among males with prostate cancer may in part be related to treatment-associated erectile dysfunction and consequent depressive symptoms.

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. Significant psychological distress may occur among males presenting with erectile disorder.

Differential Diagnosis Major depressive disorder and erectile disorder are closely associated, and erectile disorder accompanying severe depressive disorder may occur. If the erectile difficulties are better explained by another mental disorder, such as major depression, then a diagnosis of erectile disorder would not be made. The differential should include consideration of normal erectile function in males with excessive expectations. An onset of erectile dysfunction 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, which should be diagnosed instead of erectile disorder. 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 male 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 attributable to psychological events. An age younger than 40 years is also suggestive of a psychological etiology to the difficulty. Comorbidity Erectile disorder can be comorbid with other sexual diagnoses, such as premature (early)

F52.31 ejaculation and male hypoactive sexual desire disorder, as well as with anxiety and depressive disorders. The risk of depression is significantly higher in males with erectile disorder, with a markedly higher risk of depression in the first year after onset. In males diagnosed with posttraumatic stress disorder, erectile problems are common. Erectile disorder is common in males 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. Female Orgasmic Disorder Diagnostic Criteria 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 orgasm 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 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. Orgasm 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 or treatment: 1) partner factors (e.g., partner’s sexual problems, partner’s health status); 2) relationship factors (e.g., poor

Temperamental. Environmental. Genetic and physiological. 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 orgasm problems in premenopausal women vary widely, from 8% to 72%, depending on multiple factors (e.g., age, cultural background and context, duration, 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. Internationally, approximately 10% of women do not experience orgasm throughout their lifetime. Development and Course By definition, lifelong female orgasmic disorder indicates that the orgasm difficulties have always been present, whereas the acquired subtype would be assigned if the woman’s

orgasm 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 orgasmic consistency (defined as "usually or always" experiencing orgasm) are higher during masturbation than during sexual activity with a partner. Risk and Prognostic Factors A wide range of psychological factors, such as anxiety and concerns about pregnancy, can potentially interfere with a woman's ability to experience orgasm. 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 orgasm difficulties. 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

Nonsexual mental disorders. 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. Cultural views that undervalue women's sexual satisfaction or that perceive marital sex as a duty for women rather than a pleasurable activity are associated with lower help-seeking. 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, reports of the prevalence of inability to reach orgasm vary over a twofold range across world regions. Sex- and Gender-Related Diagnostic Issues By definition, the diagnosis of female orgasmic disorder is given only to women. Distressing difficulties with orgasm in men would be considered under delayed ejaculation. 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. Association With Suicidal Thoughts or Behavior Dysfunctions of sexual arousal and satisfaction have been associated with suicidal thoughts among female veterans and military service members even after adjustment for probable posttraumatic stress disorder, probable depression, history of deployment, married status, age, service in the army, and race. 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 orgasm difficulties in women, it is unclear whether relationship factors are risk factors for orgasm difficulties or are consequences of those difficulties. Differential Diagnosis If the orgasm difficulties are better explained by another mental disorder, such as major depression, then a diagnosis of female orgasmic disorder would not be made.

Substance/medication-induced sexual dysfunction. Another medical condition. Interpersonal factors. Other sexual dysfunctions. F52.22 An onset of orgasmic dysfunction 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, which should be diagnosed instead of female orgasmic disorder. If the disorder is attributable to another medical condition (e.g., multiple sclerosis, spinal cord injury), then a diagnosis of female orgasmic disorder would not be made. If interpersonal or significant contextual factors, such as severe relationship distress, intimate partner violence, or other significant stressors, are associated with the orgasm difficulties, then a diagnosis of female orgasmic disorder would not be made. 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 orgasm 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 orgasm difficulties. Female Sexual Interest/Arousal Disorder Diagnostic Criteria 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. 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, an inability to respond to sexual stimuli with sexual desire, and a corresponding lack of signs of physical sexual arousal may be the primary features. Difficulties in desire and sexual arousal may also occur simultaneously, as women with loss of sexual desire may be nine times more likely to also have lost sexual excitement or arousal. 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 the single criterion for hypoactive sexual desire disorder; this condition is now represented by female sexual interest/arousal 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”). Evidence suggests that there may be at least two types of female sexual interest/arousal disorder: one based on low sensitivity to sexual cues and a second based on overactivation of sexual inhibition. 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 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, chronic stress, 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,

Temperamental. 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, partner-related distress); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity; relationship duration); 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 Approximately 30% of women experience chronic low desire, with approximately half of these experiencing significant partner-related distress and a quarter experiencing personal distress. The prevalence of low sexual desire and of problems with sexual arousal (with and without associated distress) may vary markedly in relation to age, cultural context, 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. Though there is a strong relationship between low desire and age, the prevalence of sexrelated distress associated with low desire decreases as women 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 factors include negative cognitions and attitudes about sexuality and past history of mental disorders. Differences in propensity for sexual excitation and sexual

Environmental. Genetic and physiological. Nonsexual mental disorders. inhibition may also predict the likelihood of developing sexual problems. Environmental factors include relationship difficulties, partner sexual functioning, and developmental history, such as early relationships with caregivers

and childhood stressors. 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 reported prevalence rates of low desire across world regions, ranging from 26% to 43%. Low levels of sexual desire have been reported by some ethnoracial and migrant groups. Although lower levels of reported sexual desire and arousal may reflect less interest in sex, such group differences may be an artifact of the measures used to quantify desire and of cultural factors affecting response, such as the desirability of reporting sexual activity by nonmarried, menopausal, or widowed women. A judgment about whether low sexual desire reported by a woman from a certain ethnocultural background meets criteria for female sexual interest/arousal disorder must take into account the fact that different cultural groups may vary in norms and expectations for sexual behavior.

Sex- and 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. There are no data showing that rates or expressions of female sexual interest/arousal disorder differ between heterosexual and lesbian women.

Association With Suicidal Thoughts or Behavior Dysfunctions of sexual arousal and satisfaction have been associated with suicidal thoughts among female veterans and military service members even after adjustment for probable PTSD, probable depression, history of deployment, married status, age, service in the army, and race.

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, 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

Substance/medication use. Another medical condition. Interpersonal factors. Other sexual dysfunctions. Inadequate or absent sexual stimuli. F52.6 or arousal is completely attributable to another mental disorder, then a diagnosis of female sexual interest/arousal disorder would not be made. An onset of difficulties in desire or arousal 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, which should be diagnosed instead of female sexual interest/arousal disorder. 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. 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. 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. 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 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 problems. Low desire appears to be comorbid with depression, sexual and physical abuse in adulthood, and use of alcohol.

Genito-Pelvic Pain/Penetration Disorder Diagnostic Criteria

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
2. 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 but not in another. Although the most common clinical situation is when a female 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 vaginal penetration or other sexual activities. Some genito-pelvic pain only occurs when provoked (i.e., by intercourse or mechanical stimulation); 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 vaginal 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 females who have regularly experienced pain during vaginal penetration. 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. Symptoms of genito-pelvic pain/penetration disorder may be characterized by previous terms, including dyspareunia (pain during sexual intercourse) and vaginismus (defined by involuntary contraction of muscles making penetration painful or impossible). Specific medical disorders, such as vulvodynia (chronic idiopathic vulvar pain lasting at least 3 months) and provoked vestibulodynia (contact-induced vulvodynia localized to the vulvar vestibule), may be a primary cause of genito-pelvic pain/penetration disorder and may be a focus in studies of the disorder. Females diagnosed with these other conditions report significant distress, and their symptoms are likely to meet criteria for genito-pelvic pain/penetration disorder. Associated Features 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 females who have not succeeded in having vaginal penetration to come for treatment only when they wish to conceive. Many females 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 or treatment: 1) partner factors (e.g., partner’s sexual problems, partner’s health status); 2) relationship factors (e.g., partner responses to the pain,

including solicitous, negative, and facilitative responses; 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 females with this disorder.

Prevalence The prevalence of genito-pelvic pain/penetration disorder is unknown. However, approximately 10%–28% of females of reproductive age in the United States report recurrent pain during intercourse. Difficulties having intercourse appear to be a frequent referral to sexual dysfunction clinics and to specialist clinicians. Internationally, prevalence of genito-pelvic pain upon intercourse ranges from 8% to 28% among females of reproductive age and varies by country. Prevalence of genito-pelvic pain during sexual activities involving vaginal penetration among lesbian women relative to heterosexual women remains uncertain but may be similar or lower. Prevalence rates among other sexual minorities, including transgender women, are unknown.

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 intercourse is attempted during sexual activity. 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

Temperamental. Environmental. Genetic and physiological. a period can be established, then genito-pelvic pain/penetration disorder can be characterized as acquired. Once symptomatology is present 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. There may also be an increase in genito-pelvic pain-related symptoms in the postpartum period.

Risk and Prognostic Factors Females with antecedent mood and anxiety disorders are four times more likely to develop symptoms of genito-pelvic pain/penetration disorder compared with those without these antecedent disorders. Psychosocial factors (e.g., pain catastrophizing, pain self-efficacy, avoidance of pain, negative mood) and interpersonal factors (e.g., insecure attachment, negative partner responses to the pain, sexual motives that focus on avoiding negative relationship outcomes) may exacerbate and maintain symptoms. Females with genito-pelvic pain/penetration disorder are more likely to report a history of sexual and/or physical abuse, and fear of abuse than females without this disorder, although not all women with presenting symptoms have this history. Females experiencing superficial pain during vaginal penetration 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. Additional biomedical risk factors include early puberty, inflammation, early use of oral contraceptives, vulvar pain receptor proliferation (i.e., increase in the number of

receptors) and sensitization (i.e., touch may become perceived as pain), and lower touch and pain thresholds. Abnormalities of the pelvic floor muscles while at rest, including hypertonicity, poor muscle control, hypersensitivity, and altered contractility, may close the vaginal hiatus and interfere with penetration. **Culture-Related Diagnostic Issues** Cultural contexts can affect the experience and reporting of genito-pelvic pain related to intercourse. Affected females experience negative implications related to social narratives of womanhood, sexuality, and femininity, including pressures to prioritize men's sexual desire and penetrative sex, and depictions of sex as easy and natural. Cultural views that devalue female sexual experience may affect the way women interpret the experience of pain during sex, their help-seeking choices, and how they discuss their symptoms with their caregivers. For example, some females may not report genito-pelvic pain specifically but rather refer to being unhappy in their marriages. In the United States, Hispanic females endorse significantly higher rates of genito-pelvic pain and are more likely to report pain with first intercourse (i.e., primary genito-pelvic pain/penetration disorder) compared with non-Hispanic women. In a Minneapolis, Minnesota survey, only about half of females with genito-pelvic pain sought treatment, and those who did frequently reported feeling stigmatized. Such experiences may be heightened for

Another medical condition. sexual minorities and underserved ethnic and racialized groups, especially given evidence of inequities in pain treatment for females and African Americans. **Sex- and Gender-Related Diagnostic Issues** Gendered social constructions relating to womanhood and femininity are implicated in the experience of genito-pelvic pain/penetration disorder, including the prioritization of both penetrative sex and men's sexual desires above women's own needs and desires. The disorder is associated with feelings of shame and inadequacy as a female, contributing further to enhanced psychological distress. By definition, the diagnosis of genito-pelvic pain/penetration disorder is only given to females. There is relatively new research concerning urological chronic pelvic pain syndrome in males, suggesting that males may experience some similar problems. The prevalence of male genito-pelvic pain is estimated to be 2.2%–9.7% worldwide. The research and clinical experience are not sufficiently developed yet to justify the application of this diagnosis to males. Other specified sexual dysfunction or unspecified sexual dysfunction may be diagnosed in males appearing to fit this pattern. **Diagnostic Markers** Validated physiological measures of Criterion A2 symptoms (Marked vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts) can be assessed in real time (e.g., the cotton-swab test, vulvalgesimeter, tampon test). Although these measures are well validated for pain intensity during penetration attempts, none approximate the sexual context in which the pain is experienced, which can only be assessed via self-report. Criterion A4 symptoms (Marked tensing or tightening of the pelvic floor muscles during attempted vaginal penetration) can also be measured (e.g., via electromyographic amplitude, dynamometer, 4D ultrasound by a qualified physical therapist). There are no validated physiological measures of component symptoms for Criterion A1 or A3. Validated psychometric inventories may be used to formally assess the pain and anxiety components related to genito-pelvic pain/penetration disorder. **Functional Consequences of Genito-Pelvic Pain/Penetration Disorder** Functional difficulties in genito-pelvic pain/penetration disorder are often associated with interference in various aspects of the romantic relationship—including the initiation of such relationships—and sometimes with the ability to conceive via penile/vaginal intercourse. **Differential Diagnosis** In many instances, females with genito-pelvic pain/penetration disorder will also be diagnosed with another medical condition (e.g., lichen sclerosus, endometriosis, pelvic inflammatory disease, genitourinary syndrome of menopause). 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

Somatic symptom and related disorders. Inadequate sexual stimuli. F52.0 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 irritation associated with declining estrogen levels. The relationship, however, between genital symptoms, estrogen, and pain is not well understood. Some females 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 in DSM-5, it is not yet clear whether they can be reliably differentiated. Some females diagnosed with genito-pelvic pain/penetration disorder will also be diagnosed with a specific phobia. It is important that the clinician, in considering differential diagnoses, assess the adequacy of sexual stimuli within the female'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 (early) 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 and typically related to the lack of sexual intimacy rather than (solely) the pain itself. This is not surprising, because 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 genitopelvic 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). Females with genito-pelvic pain/penetration disorder frequently experience comorbid chronic pain conditions (e.g., fibromyalgia, chronic headaches), and the prevalence of these comorbidities increases with the severity of vulvar pain symptoms. Lesbian women also report genito-pelvic pain and penetration difficulties during sexual activities; the frequency of genito-pelvic pain/penetration symptoms among nonheterosexual women has been shown to be less than or the same as among heterosexual women. Male Hypoactive Sexual Desire Disorder Diagnostic Criteria 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 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 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 (Criterion A) 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 a reactive but temporary response to adverse life conditions. For example, the man’s low sexual desire may be related to an acute stressor or loss of self-esteem (e.g., being fired from a job or experiencing financial difficulty such as business failure). If these stressors persist beyond 6 months along with low sexual desire, then clinician judgment determines the appropriateness of the male hypoactive sexual desire disorder diagnosis.

Associated Features 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 noninitiation, 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 treatment. 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. Estimates of prevalence in representative samples range from 3% to 17%. Sexual desire problems are less common in younger men (ages 16–24), with prevalence rates between 3% and 14%, compared with older men (ages 60–74 years), with prevalence rates between 16% and 28%. However, a persistent lack of interest in sex, lasting 6 months or more, affects a smaller proportion of men (6%). Moreover, less than 2% of men report clinically significant distress associated with low desire. Studies on help-seeking behavior indicate that only 10.5% of men with sexual problems in the previous year sought help.

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. The prevalence of low sexual desire in men increases with age, from approximately 5.2% prevalence at age 27 years to 18.5% at age

Temperamental. Environmental. Genetic and physiological. 50 years. 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 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. Beliefs about sexuality (particularly restrictive sexual attitudes and conservative beliefs) are commonly associated with low sexual desire in men. Moreover, lack of erotic thoughts and concerns about erection during sexual activity are significant predictors of low sexual desire, as well as low confidence levels in erectile function. Alcohol use may increase the occurrence of low desire. Other environmental determinants of low sexual desire include problematic dyadic relationships, reduced attraction toward the partner, living in a long-term relationship, sexual boredom, and professional stress. At the larger societal level, cohort studies in a few high-income countries indicate a trend toward the decrease of sexual desire in men in recent decades. Endocrine disorders such as hyperprolactinemia and hypogonadism 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 world regions, ranging from 12.5% in Northern European men to 28% in Southeast Asian men ages 40–80 years. Distress about lack of sexual desire was significantly associated with sociocultural contexts (e.g., occupational stress) in a web-based survey across three European countries (Portugal, Croatia, and Norway). Sex- and Gender-Related Diagnostic Issues In contrast to the classification of sexual dysfunctions in women, desire and arousal disorders have been retained as separate constructs in men. Despite some similarities in the experience 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

Nonsexual mental disorders. Substance/medication use. Another medical condition. Interpersonal factors. Other sexual dysfunctions. F52.4 compared with women. However, preliminary data suggest that the overlap between sexual desire and sexual arousal (erectile function) is also very common in men, particularly when they present for help regarding sexual problems. Regarding sexual orientation, data suggest that low sexual desire is more commonly reported by gay men (19%) than by heterosexual men (9%). Differential Diagnosis 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. An onset of male hypoactive sexual desire 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, which should be diagnosed instead of male hypoactive sexual desire disorder. 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. 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. 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 Male hypoactive sexual desire disorder is rarely the sole sexual diagnosis in men. Erectile dysfunction, delayed ejaculation, and premature (early) ejaculation are often comorbid diagnoses. Depression and other mental disorders, as well as endocrinological factors, are often comorbid with male hypoactive sexual desire disorder.

Premature (Early) Ejaculation Diagnostic Criteria 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.

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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. Although the diagnostic criteria specify penile-vaginal sex, it is reasonable to assume that similar estimates of ejaculatory latency apply to males having sex with males, as well as to other sexual behaviors. 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 was previously considered to be an appropriate cutoff for the diagnosis of lifelong premature (early) ejaculation in men; however, expert consensus now considers this latency time to be too brief and instead

Temperamental. Genetic and physiological. recommends a 120-second threshold. **Associated Features** 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., 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., lack of privacy, 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, a prevalence range of 8%–30% has been reported across all ages, with even lower and higher rates in other studies. Prevalence of premature (early) ejaculation may increase with age. For example, the prevalence among males ages 18–30 in Switzerland and Turkey is about 9%–11%, while the reported prevalence of concern among males ages 50–59 in the United States about how rapidly they ejaculate may be as high as 55%. When premature (early) ejaculation is defined as ejaculation occurring within approximately 1 minute of vaginal penetration, only 1%–3% of males would be diagnosed with the disorder. **Development and Course** By definition, lifelong premature (early) ejaculation starts during a male's initial sexual experiences and persists thereafter. Some males 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 males 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. **Risk and Prognostic Factors** Premature (early) ejaculation may be more common in males with anxiety disorders, especially social anxiety disorder. 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

Substance/medication-induced sexual dysfunction. 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 differs cross-culturally and may be related to varying awareness of sexual dysfunction, concern about sexual failure, and perceptions about the importance of sex. Measured ejaculatory latencies may differ in some countries. Cultural or religious factors may contribute to these differences. For example, reports of premature (early)

ejaculation were more common in arranged marriages, because of factors such as anxiety over family pressures and lack of premarital sexual experience. Sex- and Gender-Related Diagnostic Issues Premature (early) ejaculation is a sexual dysfunction in men. Men and their sexual partners may differ in their perception of what constitutes an acceptable ejaculatory latency. There may be increasing concerns in women about early ejaculation in their sexual partners, which may be a reflection of changing societal attitudes concerning women's 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. In clinical settings, the man's estimate of the time between intravaginal penetration and ejaculation should be accepted in lieu of stopwatch measurements. Association With Suicidal Thoughts or Behavior Among males receiving treatment for premature (early) ejaculation with comorbid depression, elevated rates of suicidal thoughts or behavior have been observed; although the affected males attributed the suicidal symptoms to their premature (early) ejaculation, the presence of depression was also a likely contributing factor. Functional Consequences of Premature (Early) Ejaculation A pattern of premature (early) ejaculation may be associated with decreased self-esteem and selfconfidence, a sense of lack of control, and adverse consequences for partner relationships. It may also cause personal distress and decreased sexual satisfaction in the sexual partner. Single males are more bothered than partnered males by premature (early) ejaculation because of its interference with seeking and maintaining new relationships. Ejaculation prior to penetration may be associated with difficulties in conception. Differential Diagnosis When problems with premature (early) ejaculation are attributable exclusively to substance use, intoxication, or withdrawal,

Ejaculatory concerns that do not meet diagnostic criteria. substance/medication-induced sexual dysfunction should be diagnosed. 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 or withdrawal from 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 nonsubstance/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-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. In any case, an additional separate diagnosis of a substance use disorder is not given. 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 With mild use disorder With moderate or severe use disorder Without use disorder Alcohol F10.181 F10.281 F10.981 Opioid F11.181 F11.281 F11.981 Sedative, hypnotic, or anxiolytic F13.181 F13.281 F13.981 Amphetamine-type substance (or other stimulant) F15.181 F15.281 F15.981 Cocaine F14.181 F14.281 F14.981 Other (or unknown) substance F19.181 F19.281 F19.981 Specify (see Table 1 in the chapter “Substance-Related and Addictive Disorders,” which indicates whether “with onset during intoxication” and/or “with onset during withdrawal” applies to a given substance class; or specify “with onset after medication use”): With onset during intoxication: If 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: If symptoms developed at initiation of medication, with a change in use of medication, or during withdrawal of medication.

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 The name of the substance/medication-induced sexual dysfunction begins with the specific substance (e.g., alcohol) that is presumed to be causing the sexual dysfunction. The ICD-10-CM code that corresponds to the applicable drug class is selected from the table included in the criteria set. For substances that do not fit into any of the classes (e.g., fluoxetine), the ICD-10CM code for the other (or unknown) substance class should be used and the name of the specific substance recorded (e.g., F19.981 fluoxetine-induced sexual dysfunction). In cases in which a substance is judged to be an etiological factor but the specific substance is unknown, the ICD-10CM code for the other (or unknown) substance class is used and the fact that the substance is unknown is recorded (e.g., F19.981 unknown substance-induced sexual dysfunction). 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 severe 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 essential features of substance/medication-induced sexual dysfunction are clinically significant disturbances in sexual function that are predominant in the clinical picture (Criterion A) that are judged to be due to the effects of a substance (e.g., a drug of abuse or medication). The sexual dysfunction must have developed during or soon after substance intoxication or withdrawal or after exposure to or withdrawal from a medication, and the substances or medications must be capable of producing the symptoms (Criterion B2). Substance/medication-induced sexual dysfunction due to a prescribed treatment for a mental disorder or another medical condition must have its onset while the individual is

receiving the medication (or during withdrawal, if a withdrawal is associated with the medication). Once the treatment is discontinued, the sexual dysfunction will usually improve or remit within days to several weeks (depending on the half-life of the substance/medication and the presence of withdrawal). The diagnosis of substance/medication-induced sexual dysfunction should not be given if the onset of the sexual dysfunction precedes the substance/medication intoxication or withdrawal, or if the symptoms persist for a substantial period of time (i.e., usually longer than 1 month) from the time of severe intoxication or withdrawal. **Associated Features** 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 in men, and with arousal in women. Problems with desire and erection are less frequent. There is evidence that the effects of antidepressant medications on sexual dysfunction occur regardless of levels of depression. Approximately 30% of sexual complaints are clinically significant. Certain agents (i.e., bupropion, mirtazapine, nefazodone, and vilazodone) appear to have lower rates of sexual side effects than other antidepressants. 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 or those that do not block dopamine receptors. 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 orgasm 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. Use of 5- α -reductase inhibitors (e.g., dutasteride, finasteride) may reduce erectile function, ejaculatory function, and libido in men. 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 individuals receiving buprenorphine. Chronic nicotine or chronic alcohol abuse are associated with erectile problems. Cannabis, like alcohol, is a central nervous system depressant, and its use may be a risk factor for sexual dysfunction; however, it has also been suggested to potentially improve satisfaction with orgasm. 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, with medications such as citalopram, fluoxetine, fluvoxamine, paroxetine, sertraline, and venlafaxine having the highest rates of sexual dysfunction. 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 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 amphetamine-type substances 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 individuals 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. Sex- and Gender-Related Diagnostic Issues Some gender differences in sexual side effects from substances and medications may exist, such

Non-substance/medication-induced sexual dysfunctions. that men may more often report impairments with desire and orgasm following antidepressant use, and women may more often report difficulties with sexual arousal. Functional Consequences of Substance/Medication-Induced Sexual Dysfunction Medication-induced sexual dysfunction may result in medication noncompliance, such as stopping medications or using them irregularly, which could contribute to the lack of efficacy for antidepressants. Differential Diagnosis Many mental disorders, 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 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 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.

Revision #1

Created 2026-01-04 19:28:34 UTC by Omar Ayman

Updated 2026-01-04 19:28:34 UTC by Omar Ayman