

Marta Meana

Sexual Dysfunction in Women



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Marta Meana, PhD, is a renowned sex researcher and therapist whose work on female sexuality has been widely published in the academic literature and extensively covered in national and international popular media. Professor of psychology at the University of Nevada, Las Vegas, she is president of the Society for Sex Therapy and Research, associate editor of the *Archives of Sexual Behavior*, and an advisor to the DSM-5 Workgroup on Sexual and Gender Identity Disorders.

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Preface

Nearly everyone will experience sexual difficulties at some point in the course of their lives. For many, these difficulties will at times rise to the level of a sexual dysfunction, as currently defined by the latest edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision (DSM-IV-TR; APA, 2000). This may be especially true for women. They consistently report less desire, arousal, and orgasm frequency than men, as well as more pain associated with penetration. Sexual dysfunctions are possibly the most prevalent of any of the disorders in the DSM. Their apparent ubiquity thus raises two important questions: (1) Might our definitions of sexual dysfunction be overinclusive and consequently serve to pathologize what are in fact typical sexual variations – a normal diversity of experience? (2) Why do most clinical psychologists feel less well equipped to treat sexual dysfunction than they do major depression or anxiety disorders, which are nowhere near as prevalent?

The first question is currently being hotly debated in the literature and in ongoing attempts to modify diagnostic criteria for female sexual dysfunctions in the next edition of the DSM (more on this to follow). The debate is fueled by concerns that current definitions of female sexual dysfunction have been derived from a male sexuality analog that assumes sex to be a pure drive (like hunger), divorced from its complex psychological, relational, and social contexts. The debate is really about the accurate definition of sexual function for women. Although the discussion may at times seem academic, it has important implications for clients and for their therapists, as both try to align expectations with reality while allowing for the wide diversity of sexual experience that exists.

In regard to the second question, most clinical psychologists feel inadequate in the treatment of sexual dysfunction primarily because they lack training. Although there are psychologists who specialize in anxiety and depression, it is expected that every graduate from a clinical psychology program in North America will be competent in the treatment of these disorders. Unfortunately, that is not the case for sexual dysfunction, despite its prevalence. A discussion of why this is so is beyond the scope of this book, but attempting to redress the lack of training is at its heart. Clinical psychologists can most definitely help their clients navigate and address sexual problems effectively. Sex therapy, after all, is based on many of the same theories, principles, and techniques that guide many other interventions (Binik & Meana, 2009).

I want to thank Dr. Danny Wedding, as well as Robert Dimbleby of Hogrefe Publishing, for inviting me to participate in this series and to bring the treatment of female sexual dysfunction into the general fold of our discipline. Too many women are suffering from sexual difficulties for us to restrict their care. I am indebted to the University of Nevada, Las Vegas, for the sabbatical leave that facilitated the writing of this book and to Sarah Jones and Taylor Oliver

for their research assistance. Importantly, I also want to thank Tim, Candy, Camilla, and Miko – my circle of love.

Marta Meana, PhD
Las Vegas, NV

Dedication

A mi padre, Antonio Meana.

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1

Description

1.1 Terminology

There are six sexual dysfunctions in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000) that apply or are specific to women's sexual response: hypoactive sexual desire disorder (HSDD; 302.71), sexual aversion disorder (SAD; 302.79), female sexual arousal disorder (FSAD; 302.72), female orgasmic disorder (FOD; 302.73) (sometimes referred to as anorgasmia), dyspareunia (not due to a medical condition) (302.76), and vaginismus (not due to a medical condition) (306.51). There have been few changes in terminology from the publication of the revised third edition of the DSM, although current proposals for changes to the DSM-5 (expected publication date in 2013) promise significant alterations to current diagnostic categories. The terminology in the *International Statistical Classification of Diseases and Related Health Problems*, 10th Edition (ICD-10; World Health Organization, 1992) is semantically similar to that in the DSM-IV-TR, with the exception of the inclusion in the ICD-10 of a sexual dysfunction (excessive sexual drive) currently being considered as an appendix addition to the DSM-5. See Table 1 for a comparison of terminology across diagnostic manuals.

The six female sexual dysfunctions in the DSM-IV may be collapsed into three for the upcoming DSM-5

Table 1
Comparison of Terminology Across Diagnostic Manuals for Sexual Dysfunctions in Women

DSM-III-R	DSM-IV-TR	ICD-10 (codes)	DSM-5 Proposed (as of April 1, 2012)
Sexual Desire Disorders			
HSDD	HSDD (302.71)	Lack or loss of sexual desire (F52.0)	<i>Sexual interest/arousal disorder in women</i>
SAD	SAD (302.79)	Sexual aversion and lack of sexual enjoyment (F52.1)	<i>Possible removal</i>

Table 1 continued

DSM-III-R	DSM-IV-TR	ICD-10 (codes)	DSM-5 Proposed (as of April 1, 2012)
Sexual Arousal Disorders			
FSAD	FSAD (302.72)	Failure of genital response (F52.2)	<i>Sexual interest/ arousal disorder in women</i>
Orgasm Disorders			
Inhibited female orgasm	FOD (302.73)	Orgasmic dysfunction (F52.3)	FOD
Sexual Pain Disorders			
Dyspareunia	Dyspareunia (N/GMC)	Nonorganic dyspareunia (F52.6)	<i>Genito-pelvic pain/ penetration disorder</i>
Vaginismus	Vaginismus (N/GMC)	Nonorganic vaginismus (F52.5)	<i>Genito-pelvic pain/ penetration disorder</i>

Note. DSM-III-R = *Diagnostic and Statistical Manual of Mental Disorders*, 3rd Edition (APA, 1987); DSM-IV-TR = *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text revision (APA, 2000); FOD = female orgasmic disorder; FSAD = female sexual arousal disorder; HSDD = hypoactive sexual desire disorder; ICD-10 = *International Statistical Classification of Diseases and Related Health Problems*, 10th Edition (World Health Organization, 1992); N/GMC = not due to a general medical condition; SAD = sexual aversion disorder.

1.2 Definition

To understand both existing and proposed criteria for the sexual dysfunctions in women, it is necessary to briefly review the model of the sexual response that has had the most influence on our definitions of dysfunction. A simultaneously physical and psychological experience, the sexual response engages both the brain and the body. From genital engorgement to lubrication to autonomic arousal to cognitive and emotional processes to relational ones, the sexual response is indeed a full body/mind experience. Partnered sex doubles the complexity as two body/mind experiences meet and influence each other.

1.2.1 Traditional Models of the Sexual Response

Masters and Johnson

Despite the acknowledged complexity of the sexual response, definitions of dysfunction have been most influenced by the model introduced by Masters and Johnson (1970), whose research focused on the autonomic and genital aspects of sexuality. They proposed that the sexual response basically progressed through four distinct and sequential phases: excitement, plateau,

The sexual response is simultaneously a psychological and physiological experience

orgasm, and resolution. The excitement phase in women was described as consisting of:

- genital and clitoral engorgement,
- vaginal lubrication,
- swelling of the breasts and nipple erection, and
- increases in autonomic arousal, including heart rate and blood pressure.

The plateau phase was described as a period of maximum arousal just prior to orgasm, wherein the outer third of the vagina becomes hypertonic while the inner part expands. In addition, the uterus moves up in the pelvic cavity, and the clitoral glans retreats under its hood. The orgasm phase consists of spasmodic contractions of the pelvic floor muscles, at which time autonomic arousal peaks and is generally accompanied by an intense subjective feeling of pleasure. The resolution phase was basically described as the period during which the process of vasocongestion and autonomic arousal reversed itself.

Kaplan and Lief

The Masters and Johnson model was physiologically focused and linear. The sexual response started at one phase and progressed sequentially through to its end. Missing from the model, however, was a motivational state that would lead one to seek stimuli that would initiate the sexual response or to be responsive to said stimuli if they presented themselves. That motivational state, which we commonly refer to as sexual desire, was independently proposed by Kaplan (1977) and Lief (1977) as an integral first phase of the sexual response. The resulting triphasic model consisted of desire, excitement (subsuming Masters and Johnson's plateau phase), and orgasm. The new model of the sexual response retained the linear structure of the original one.

Having defined the "normal" sexual response, the aforementioned models provided the frame for the definitions of sexual dysfunction in the various editions of the DSM to date. Things could go awry at any one of three phases of the sexual response. A woman could have or develop problems of desire (HSDD or SAD), or problems relating to arousal (FSAD), or problems relating to orgasm (FOD). Pain with sex was a dysfunction that stood apart from these phases, although desire and arousal problems were often blamed, with little empirical support, for the existence of dyspareunia and vaginismus. More likely, as we shall see, it is pain with sex that leads to problems in all phases of the sexual response.

1.2.2 Challenges to Traditional Models of the Sexual Response

Since the publication of the DSM-IV in 1994, theorizing and research on women's sexuality has increased significantly. The results of these efforts have raised doubts about the extent to which the models of the sexual response that have shaped DSM diagnostic criteria accurately represent the sexual experience of women. In question are the implicit assumptions that (1) sexual desire is a spontaneous drive, (2) the sexual response is necessarily linear in its progression, (3) desire and arousal are separate constructs, and (4) psychological, relational, and social contexts and motivations are secondary to the physiologi-

Traditional models of the sexual response may not adequately depict the diverse experience of women

cal aspects of the sexual response. An accumulating body of evidence suggests that these assumptions may represent an inaccurate depiction of female sexuality. New models of the sexual response are being proposed to integrate empirical findings that suggest a more complex process.

Incentive-Motivation Model

A group of Dutch researchers have proposed an incentive-motivation model of the sexual response that veers away from desire as a spontaneous, internally generated drive (e.g., Both, Spiering, Everaerd, & Laan, 2004). They maintain that sexual motivation emerges in response to sexual stimuli which are then processed (sometimes below the level of consciousness) and give rise to sexual action. Sexual desire occurs when the physiological changes associated with arousal are consciously perceived by the individual. Note that in this model, arousal precedes desire, although the two might be difficult, if not impossible, to distinguish. Desire is considered the conscious/cognitive experience that propels sexual action once arousal has been detected. In addition, this model proposes that individuals differ in their propensity to be aroused or motivated toward sexual action, and that this propensity may be contingent on psychological, neuropsychological, and cultural factors. The incentive-motivation model has posed an impressive empirically supported challenge to the sequence proposed by traditional models of the sexual response. Desire may not, after all, precede arousal. Desire may sometimes be a response rather than an originating, spontaneous drive.

Basson's Model

In support of the ideas inherent in the incentive-motivation model, Basson (2007) has provided a circular model of the sexual response, applicable to both men and women, although it originated in response to the failure of traditional models to account for the experience of a significant number of women. In a series of expert opinion papers, she argued the following:

In some women, desire may be experienced as responsive rather than spontaneous with relational factors playing a substantial role

- A significant number of women do not report spontaneous desire, although they respond positively to sexual stimuli and feel desire primarily in response to such stimuli.
- The motivation for sex may often be nonsexual (e.g., emotional intimacy) but nonetheless result in arousal and desire.
- Competent sexual stimuli produce sexual arousal which, in turn, produces sexual desire (the motivation to get more of what feels good).
- What feels good encompasses more than mere sexual release. Pleasure also emanates from many associated rewards, such as feelings of closeness, intimacy, and love.

Some of these contentions and clinical observations have been supported by literature indicating that it is empirically difficult to tease apart sexual desire from sexual arousal. Women themselves are not able to reliably distinguish between the two (Brotto, Heiman, & Tolman, 2009; Graham, Sanders, Milhausen, & McBride, 2004). Finally, thrown into the mix is a literature that urges the field to consider the complex nonphysiological context in which sex takes places, including social and economic forces impinging on the freedom and expression of women (Tiefer, 2001). Within the past decade, the Masters and Johnson / Kaplan/Lief model started to look simplistic. Basson's model of

the sexual response suggested multiple motivational starting points and fluid subsequent phases, the order of which varied when and if you could actually tease them apart.

The jury is out on which of these two sets of models best accounts for women's sexual responses (for reviews, see Hayes, 2011; Meana, 2010). The conclusion most likely to emerge is that there is a diversity of sexual responses. The linear model may be more representative of some women, while the circular model may be more representative of others. It is also likely that there are life-span and situational differences. Seemingly spontaneous, uncomplicated desire and arousal may be more common at younger ages, in newer relationships, or during periods of low stress. The more responsive, more situation-contingent version of sexual responding may be more representative of women as they age, during challenging life periods, or in long-term relationships. Regardless, the research of the last few years has clearly illustrated what most clinicians already knew impressionistically – that sexuality is complex and exists within a system that extends far beyond genital plumbing.

1.2.3 Sexual Dysfunctions in Women

Challenges notwithstanding, the Masters and Johnson/Kaplan/Lief model of sexual function remains the backdrop against which the DSM-IV sexual dysfunction criteria were devised. Recent research and the incentive-motivation and Basson models provide the frame for proposed revisions in the coming edition (DSM-5). The following section will consequently describe both current definitions and criteria, as well as summarize the latest recommendations for new ones. The best starting point is the criteria shared by all dysfunctions not attributed to general medical conditions, substance use, or medications.

All of the sexual dysfunctions have three diagnostic criteria (A, B, and C). Criterion A details the characteristics of each dysfunction. Criterion B (“The disturbance causes marked distress or interpersonal difficulty”) is identical in all of them. This criterion stipulates that if the sexual presentation does not sufficiently concern the individual or cause any relationship problems, it is not diagnosable as a sexual dysfunction. This is a controversial criterion. Some think it is important to maintain it so that we do not pathologize individuals who are satisfied with their level of sexual function, whatever that may be (Meana, 2010). Others emphasize that no such concerns have overridden the diagnosis of other disorders in the DSM, for obvious reasons (e.g., a happy person with schizophrenia still has schizophrenia); a woman who has no orgasms still has orgasmic disorder whether she cares about it or not (Althof, 2001). Critics of the distress criterion have suggested that it become a specifier (i.e., an addendum that further describes the situation rather than determines the existence of a disorder). Current drafts of proposals for the DSM-5 appear to be maintaining the distress criterion despite objections.

Criterion C varies only slightly across dysfunctions and stipulates that the dysfunction cannot be better accounted for by (1) another Axis I disorder (except another sexual dysfunction), (2) the direct physiological effects of a substance (e.g., a drug of abuse, medication), and/or (3) a general medical condition. Exceptions occur in the case of SAD and the two sexual pain disor-

ders. In the case of SAD, neither substances/medications nor general medical conditions are invoked as possible causes of the disorder. In the case of dyspareunia, the existence of vaginismus or lack of lubrication overrides the primary diagnosis of dyspareunia. In the case of vaginismus, substances/medications are not mentioned as possible culprits. Dysfunctions at any stage of the sexual response cycle that are attributed primarily to a general medical condition or to substance use or medication use have separate codes in the DSM-IV and will not be covered in this text.

All sexual dysfunctions in the DSM-IV-TR also have three dichotomous specifiers. The first (lifelong type / acquired type) relates to the onset of the disorder. The second (generalized type / situational type) refers in a basic way to contextual factors: Does the difficulty present itself in all situations, or is it limited to specific ones? The third specifier addresses etiology (due to psychological factors / due to combined factors). This last specifier is the most problematic as it asserts the possibility of disengaging physical from psychological factors in the sexual response. Arguably, such disengagement is neither within the reach of our current knowledge nor particularly realistic, considering that the sexual response is simultaneously physical and psychological.

Table 2
Criterion A for Each of the Sexual Dysfunctions Applicable to Women in DSM-IV-TR

Dysfunction	Monosymptomatic Criterion A
HSDDD	Persistently or recurrently deficient (or absent) sexual 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 the context of the person's life.
SAD	Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.
FSAD	Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.
FOD	Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of FOD should be based on the clinician's judgment that the woman's capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.
Dyspareunia	Recurrent or persistent genital pain association with sexual intercourse.
Vaginismus	Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

Note. DSM-IV-TR = *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text revision (APA, 2000); FOD = female orgasmic disorder; FSAD = female sexual arousal disorder; HSDDD = hypoactive sexual desire disorder; SAD = sexual aversion disorder.

The next three sections will describe each of the six female sexual dysfunctions, with a focus on Criterion A, which consists of the monosymptomatic defining characteristic of each disorder (Table 2).

Sexual Desire and Arousal Disorders

With regard to, or applicable to, women, the DSM-IV-TR lists two sexual dysfunctions related to purported impairments in sexual desire (hypoactive sexual desire disorder [HSDD] and sexual aversion disorder [SAD]) and one related to impairments in arousal (female sexual arousal disorder [FSAD]). The desire disorders are not defined in a gender-differentiated way, while, clearly, FSAD relates to aspects of female sexual arousal exclusively.

HSDD is defined as a persistent or recurrent deficiency or absence of sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is left to the clinician, and the DSM specifies that this judgment be made in the context of potentially relevant factors, such as the person's age and the circumstances of their life. Although fantasies feature prominently in the definition of HSDD, most women who present with this problem are not concerned about their fantasy life. They are typically in relationships, and they present with distress about a level of desire that is disturbing to them and/or to their partners.

There are a number of ways HSDD can present, including:

- (1) the single woman who has never had much sexual desire and is distressed by the fact that the world seems to revolve around something that barely registers for her (rare);
- (2) the partnered woman who never had much desire for sex and was unconcerned about it until it started to interfere with a valued relationship (more common);
- (3) the partnered woman whose level of sexual desire has decreased to an extent that is distressing to her and usually to her partner (quite common);
- (4) the woman who would not be personally distressed by her level of desire were it not for the dissatisfaction and distress of her partner (quite common).

The distress can range from a wistful longing for an old feeling that appears to have faded, to symptoms of depression centered on the loss or decrease of desire. The interpersonal difficulty can range from a vague frustration about lack or loss of intimacy, to serious relationship-threatening discord over sexual frequency.

It is important to emphasize that HSDD is not diagnosed in relation to norms of sexual desire. There are no reliable norms regarding how often most women feel desire, and even if there were, they would not be particularly useful. Without distress or interpersonal difficulty, women would have no reason to seek help. If a woman does not want something and no one else wants her to want it, one could argue that there is no problem, even if the distress/interpersonal criterion is ignored. However, women do seek help because they are unhappy with their desire levels and/or because their partners are dissatisfied with the frequency of sex in the relationship. In concert with a voluminous research indicating a large difference in sexual desire/drive between men and women (Baumeister, Catanese, & Vohs, 2001), desire discrepancies feature

Deciding what is deficient sexual desire is a relative endeavor, as it is often measured against social expectations or a partner's desire

prominently in clinical cases. This makes the diagnosis of HSDD in women tricky because (1) the partner's level of desire may be unduly influential in the assessment of the woman's supposed problem, and (2) by definition, the diagnosis pathologizes the partner with less desire, who, in heterosexual relationships, is more often than not the woman.

SAD is defined as persistent or recurrent extreme aversion or avoidance of all or most sexual activity with a sexual partner. Women with SAD generally present with feelings of revulsion regarding sex. The disgust is sometimes centered on a specific aspect of sex, such as genital secretions, but it is more often generalized to multiple, if not all, aspects of the sexual experience. Exposure to sexual stimuli or the prospect of sexual activity is aversive and can be accompanied with anxiety, fear, and anger at the perceived pressure to engage in acts that they find revolting.

The intensity of the aversion can range from mild anxiety and/or lack of pleasure to panic attack symptoms, including heart palpitations, shallow breathing, nausea, and dizziness. In most cases, the avoidance of sex is quite severe as these women will go to great lengths to avoid sex with their partners. Partners also report that when they do have sex, the disgust is usually quite apparent in facial expressions (e.g., wincing) and bodily movements (e.g., cringing). Consequently, the most common presentation of SAD is at the behest of a partner or out of the woman's concern for a relationship suffering under the stress of her aversion to sex.

The DSM-IV's inclusion of SAD under the sexual desire disorders clearly indicates the theory that SAD represents a deficit in desire. However, its clinical presentation is quite different from HSDD. There is clearly no sexual desire, but the distress generally relates to the perceived pressure to have sex rather than to the unfulfilled wish that desire would be present or return. In therapy, women with SAD can be quite expressive about their disgust and very anxious about treatment that will necessitate some hierarchy of exposure to sexual stimuli, no matter how finely graded the hierarchy. In contrast, women with HSDD are more likely to welcome ideas/exercises that might have a positive impact on their desire. As such, emotions, cognitions, and behavior that accompany SAD often appear to have much in common with Specific Phobia. On the other hand, mild levels of disgust and behavioral avoidance are also present in some women with HSDD (Sims & Meana, 2010). The question is thus whether SAD exists on the extreme negative end of a continuum of sexual desire or whether it represents a categorically different disorder governed by a different set of factors. In other words, is it more of an anxiety disorder or a sexual dysfunction?

FSAD is defined as a persistent or recurrent inability to attain or maintain an adequate level of vasocongestion and lubrication until the completion of sexual activity. This is clearly the sexual dysfunction that relates directly to the "excitement" phase of the sexual response, with excitement being defined exclusively in terms of changes related to arousal in the genitals. The literature, however, does not show much support for the existence of this dysfunction. It is reportedly rare for women to present with FSAD only, or with FSAD as their chief complaint (Graham, 2010a). There are a number of reasons this might be the case: (1) the high comorbidity between FSAD and other sexual dysfunctions, (2) lack of differentiation between desire and arousal, and (3)

Most women do not make much of a distinction between desire and arousal

low levels of distress associated with impairments in physical indicators of arousal. Barring medical conditions or vaginal changes associated with age and menopause, women do not often report problems with physical arousal separate from problems with desire or orgasm or pain.

Sexual interest/arousal disorder in women is the new diagnostic category currently proposed for the coming edition of the DSM (DSM-5) (American Psychiatric Association, 2012). This category would subsume the current diagnoses of HSDD and FSAD with the rationale that (1) neither the empirical literature nor women themselves reliably distinguish desire from arousal, and (2) the high degree of comorbidity between the two diagnoses makes their separation questionable. In its preliminary draft, this proposed diagnostic category consists of a polythetic Criterion A requiring at least three out of five indicators of lack of sexual interest/arousal (absent or reduced interest in sexual activity, erotic thoughts/fantasies, initiation/receptivity, excitement/pleasure, genital/nongenital sensations) that have persisted for at least 6 months. Criterion B maintains distress or impairment. In addition to typifying whether the dysfunction is of the lifelong or acquired type, there is also a proposed list of six specifiers intended to reflect the various contextual and medical factors that can be implicated in any one woman's difficulty (generalized/situational, partner factors, relationship factors, individual vulnerability factors, cultural/religious factors, medical factors).

This new proposed diagnostic category recommended by the DSM-5 Workgroup on Sexual and Gender Identity Disorders will be subjected to further review and expert feedback, which may result in significant changes to this draft. The Workgroup has also recommended that SAD be removed as a distinct sexual dysfunction given its greater similarity to specific phobia.

Orgasm Disorder

Female orgasmic disorder (FOD) is defined as persistent or recurrent delay or absence of orgasm following a normal arousal phase. The DSM definition acknowledges that there is a wide variability in the type and intensity of stimulation that triggers orgasm and, as such, leaves it up to the clinician to determine if the woman's orgasmic capacity is less than might be expected for her age, sexual experience, and the competence of the stimulation she receives.

One would think that FOD would be relatively easy to diagnose since, unlike desire and arousal, it purportedly pertains to a discrete event. However, this is not necessarily the case. Unlike men, who usually ejaculate with orgasm, no such discrete event occurs with orgasm in women. Attempts to define orgasm have thus relied on extremely varied subjective descriptions (Mah & Binik, 2001), and a significant number of women are unsure whether or not they have experienced an orgasm (Meston, Hull, Levin, & Sipski, 2004). The other complicating factor in defining FOD relates to the competence of the stimulation the woman is receiving.

Despite decades of data indicating that the majority of women require clitoral stimulation to reach orgasm, there is a persistent expectation in the public that women should be having orgasm through intercourse. It is thus not unusual for couples to present in therapy with concerns about the woman's orgasmic capacity because she fails to reach orgasm through penetration alone. Another factor that makes the diagnosis of FOD far from obvious is the

A majority of women do not reach orgasm from the stimulation provided by intercourse alone

fact that, in contrast to men, there is great variability in the extent to which women find orgasm an important component of their sexual experience and satisfaction.

The DSM-5 Workgroup on Sexual and Gender Identity Disorders recommends that the diagnosis of FOD be maintained but that it be elaborated to include reduced intensity of orgasmic sensations and to account for the expected high comorbidity with sexual interest/arousal disorders as well as the varied contextual factors (the aforementioned six specifiers) that could be affecting the experience of orgasm (American Psychiatric Association, 2012).

Sexual Pain Disorders

The DSM-IV-TR lists two sexual pain disorders. One is applicable to both men and women: dyspareunia (not due to a general medical condition). The other is specific to women: vaginismus (not due to a general medical condition).

Dyspareunia is described simply as recurrent or persistent genital pain associated with sexual intercourse. The pain cannot be caused exclusively by vaginismus or lack of lubrication. Pain associated with sexual intercourse occurs primarily during penetration, but in some women, it can last for hours and even days after the sexual encounter. Although this pain had traditionally been linked etiologically with sexual activity, the genital pain of dyspareunia is also experienced with other types of penetration or stimulation to the genital area (e.g., tampon insertion, finger insertion, gynecological examinations, and varied other types of genital contact) (Meana, Binik, Khalife, & Cohen, 1997a). In fact, research indicates that the pain–sex link might be incidental in the majority of cases (Binik, 2010a). Pain is experienced during sex not because of any psychosexual or relational conflict, but rather because sex involves the mechanical stimulation of a hyperalgesic area. The penis, speculum, and tampon are all simply pain stimuli making contact with tissue that has become hypersensitive.

The clinical presentation of dyspareunia is typically quite clear. Women generally report a significant amount of distress about the fact that they find intercourse anywhere from moderately painful to excruciating. However, the question of how to rule out – or even whether we should rule out – a general medical condition is not clear at all. There are a number of conditions of unknown etiology (provoked vestibulodynia [PVD] being the most prominent) that probably account for the majority of cases of dyspareunia in premenopausal women. PVD is characterized by a severe, burning/sharp pain that occurs in response to pressure localized in the vulvar vestibule, which is essentially the entry point to the vagina. Conditions such as these often go unrecognized because the only obvious symptom to the untrained professional is pain with intercourse. Consequently, it is easy to psychologize or sexualize the symptoms, despite the fact that there are very few accounts in the empirical literature of what could reasonably be termed “psychogenic dyspareunia.” Psychological and relational factors are important mediators of the experience of dyspareunia, but there are precious few data indicating that they give rise to the disorder.

Vaginismus is described as a recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. Interestingly, no mental health professional is in a position to

Most women with dyspareunia have a pain condition that interferes with intercourse rather than a sexual problem resulting in pain

verify this uniquely physical criterion appearing in a mental health manual. Furthermore, no woman presents clinically with this description. Typically the woman with vaginismus presents with intense fear of vaginal penetration, descriptions of penetration attempts as painful and distressing, and assertions that penetration is either impossible or close to impossible much of the time. Many of these women have similar fears and avoidance of gynecological exams. In fact, the vaginal muscle spasm definition of vaginismus appears to be based primarily on expert opinion, as there is no empirical evidence to support vaginal/pelvic muscle spasm as the defining characteristic of vaginismus (Binik, 2010b).

Recent research has cast doubt on our ability to reliably distinguish vaginismus from certain types of dyspareunia (e.g., PVD). They both share reports of pain with sexual intercourse and with gynecological examinations, and both are characterized by an avoidance of penetration. It could be that vaginismus exists on the extreme end of a behavioral/affective continuum of dyspareunia. The one distinguishing characteristic may be fear and distress about vaginal penetration and pain, with women who typically receive the diagnosis of vaginismus suffering more from both (Reissing, Binik, Khalife, Cohen, & Amsel, 2004).

Genito-pelvic pain/penetration disorder is the new diagnostic category proposed for the DSM-5 (American Psychiatric Association, 2012). Originally, the radical recommendation was that this diagnostic category be entirely removed from the sexual disorders section of the DSM and be reclassified into the pain disorders section of the manual. The rationale was that the data support a conceptualization of dyspareunia and vaginismus as pain disorders that happen to interfere with sex, much as other pain disorders interfere with sex and other aspects of daily living. Calling them sexual pain disorders and classifying them with the other sexual dysfunctions inaccurately elevates the role of sex in their development. Furthermore, the new category would subsume the current diagnoses of dyspareunia and vaginismus, with the rationale that there is no current empirical basis for the differentiation between these two diagnoses. The latest draft of the proposal (last updated July 29, 2011) appears to indicate that genito-pelvic pain/penetration disorder, if adopted, will continue to be classified as a sexual dysfunction. The proposed criteria require persistent or recurrent difficulties with at least one of the following: inability to have vaginal intercourse/penetration, vulvovaginal or pelvic pain during penetration attempts, fear or anxiety about pain or penetration, tensing of pelvic floor muscles during vaginal penetration attempts. As in the case of the other two proposed categories, the distress criterion and onset sub-type are retained, while a list of specifiers is added to cover contextual influences.

1.3 Epidemiology

After decades of reliance on convenience and clinical samples, large-scale national and cross-national epidemiological surveys providing valuable prevalence data have been conducted in the last 15 years. Other than variations in the wording of question items, there are two important points to consider

when interpreting the data across studies. The first of these is the time frame covered by the question. Some questions inquire whether the symptom lasted at least 1 month, while others cover at least 6 months, or a period of several months in the last year. Answers vary significantly according to the time frame indicated. The DSM-IV-TR's use of "persistent and recurrent" in Criterion A for all sexual dysfunctions leaves undefined how long the problem has to have existed for a diagnosis to be made (the proposed revisions to the DSM are more specific about duration and frequency of symptoms).

The second important point to consider is whether the women surveyed are distressed by the problem or whether the problem is causing relationship discord (Criterion B of all sexual dysfunctions in the DSM-IV). As we shall see, reports of sexual problems with associated distress are far less prevalent than reports of sexual symptoms without concomitant distress. Although the absence of distress should preclude a diagnosis as per the DSM-IV, it remains informative to consider women's reports of their sexuality, whether or not distress is present.

1.3.1 Low Desire or Interest in Sex

Across studies, low sexual desire has been shown to be highly prevalent in women. Because of the potential of gender desire discrepancies contributing to the inflation of HSDD diagnoses in women, data for men are here reported when possible. In the National Health and Social Life Survey (NHSLs), 27% to 32% of sexually active women ($n = 1,749$) and 13% to 17% of men ($n = 1,410$) in the United States aged 18 to 59 reported lack of interest in sex over several months or more in the prior year (Laumann, Paik, & Rosen, 1999). In the National Survey of Sexual Attitudes and Lifestyles (Natsal), 40.6% of 5,530 women in Britain aged 16 to 44 reported lack of interest in sex of 1 month's duration over the prior year, in contrast to 17.1% of men surveyed (Mercer et al., 2003). Lack of interest in sex lasting at least 6 months in the past year was reported by 10.2% of women and 1.8% of men. Although the numbers dropped considerably when the time frame was extended, low sexual desire remained the most common complaint in women in the Natsal, as well as in the Global Study of Sexual Attitudes and Behaviors (GSSAB). The latter found a prevalence of 26% to 43% for lack of interest in sex among those sexually active in their sample of 13,882 women from 29 countries, aged 40 to 80 years (Laumann et al., 2005), compared with a prevalence of 13% to 28% in men.

Clearly, many women report low levels of sexual desire, but we do not generally know how women arrive at their sexual desire self-assessment. No study has systematically investigated what or who women are comparing with when they rate their desire levels. Are they comparing their level of desire to an earlier, more intense, level, or are they comparing their desire with that of men and consequently judging their desire levels accordingly, even when they do not care about the difference? Nicolson and Burr (2003) have suggested that the sexology literature has promoted the existence of a mythical standard of female sexuality against which women measure themselves. Without this assumption regarding how much desire is normative or "healthy," perhaps fewer