REPORTS

Considerations for Diagnostic Criteria for Erectile Dysfunction in DSM V

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ABSTRACT

Introduction. The Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., text revision (DSM-IV-TR) criteria for erectile disorder have been criticized as multiple grounds including that the criteria lack precision, that the requirement of marked distress is inappropriate, and that the specification of etiological subtypes should be deleted.
Aim. The goal of this manuscript is to review evidence relevant to diagnostic criteria for erectile disorder published since 1990.
Method. Medline searches from 1990 forward were conducted using the terms erectile disorder and impotence. Early drafts of proposed alterations in diagnostic criteria were submitted to advisors.
Main Outcome Measure. Evidence regarding modification of criteria for DSM V diagnostic criteria for erectile dysfunction was judged by whether existing data justified the adoption of precise criteria which would lead to homogenous groups for research. Another outcome measure was whether data exist to reliably differentiate fluctuations in normal function from pathological states.
Results. The literature review revealed a large literature concerning erectile disorder but minimal evidence concerning an operational definition for this disorder.
Conclusions. It is recommended that erectile disorder be precisely defined in order to clearly differentiate alterations in normal function from a condition requiring medial intervention and to facilitate clinical research. It is specifically proposed that erectile dysfunction be defined as failure to obtain and maintain an erection sufficient for sexual activity or decreased erectile turgidity on 75% of sexual occasions and lasting for at least 6 months. It is also recommended that erectile disorder be defined independently of distress. **Segraves RT. Considerations for diagnostic criteria for erectile dysfunction in DSM V. J Sex Med 2010;7:654–671.**

Key Words. Erectile Disorder; Sexual Dysfunction; Arousal Disorder; Diagnostic Criteria

Nomenclature and criteria sets for erectile dysfunction have changed in various versions of the DSM. In the DSM III [1], both sexes could get a diagnosis of inhibited sexual excitement. In males, this was defined as "partial or complete failure to attain or maintain erection until completion of the sexual act."

In DSM IIIR [2], the name was changed to male erectile disorder to reflect current usage. A literature review had indicated minimal use of the term inhibited male excitement. Both physiological and subjective criteria were utilized in the definition. Male erectile disorder could be diagnosed by one of two criteria: (i) persistent or recurrent partial or complete failure in a male to obtain or maintain erection until completion of sexual activity or (ii) persistent or recurrent lack of a subjective sense of sexual excitement and pleasure in a male during sexual excitement. According to DSM III R, a male with normal erectile capacity but lack of subjective arousal could have been diagnosed as having an erectile dysfunction. In practice, this disorder was rarely diagnosed on the basis of the subjective criteria alone.

In DSM IV [3], various modifications of the criteria for male erectile disorder were introduced.

The subjective criteria was eliminated, a distress criteria was added as well as subtypes. In DSM IV and DSM IV TR [4], the following three criteria were required to diagnose male erectile disorder: (i) persistent or recurrent inability to attain, or to maintain until completion of the sexual act, an adequate erection; (ii) the disturbance causes marked distress or interpersonal difficulty; and (iii) the erectile disorder is not better accounted for by another axis one disorder (other than a sexual dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse a medication) or a general medical condition. Also, the clinician was asked to specify whether the disorder is lifelong or acquired, generalized or global, due to psychological or combined factors.

The lack of specificity of these criteria are obvious [5]. These criteria do not specify how frequently the problem must occur before it reaches diagnostic significance. The criteria also do not specify duration.

Historical Context

To appreciate the issues involved in consideration of criteria sets for erectile dysfunction in DSM V, a number of issues must be considered.

First, one must evaluate the effects of advances in knowledge concerning the diagnosis and treatment of erectile dysfunction have had on diagnostic considerations. In particular, it is difficult to separate a consideration of current diagnostic criteria from the impact of the advent of PDE5 inhibitors on clinical practice and conceptualization concerning etiology. Sildenafil was introduced in 1998. The full impact of the introduction of the phosphodiesterase type 5 (PDE-5) inhibitors had not been appreciated before the introduction on DSM IV TR in 2000.

Another issue which has had a marked impact on nosology is the complex interface between biological and psychological factors in sexual function. In previous versions of the DSM, criteria sets were developed to diagnose psychological factors and totally biogenic sexual dysfunction was not meant to be subject to criteria developed in the DSM. However, this distinction has been criticized as presuming a level of knowledge regarding etiology which simply does not exist. Although some case of erectile dysfunction can be described as almost certainly organic (e.g., in long standing multiple sclerosis) or almost certainly psychogenic (e.g., a young male in his first sexual encounter), many cases are of mixed or of uncertain etiology.

The history of the treatment of erectile dysfunction has been summarized recently by Bancroft [6]. In 1970, the publication of Human Sexual Inadequacy by Masters and Johnson [7] prompted the introduction of psychologically based therapies for all sexual problems. At that time, most sexual problems, including erectile problems, were considered to be psychological in origin. The major intervention for organic erectile dysfunction was the penile implant, an irreversible procedure [8]. At that time, there was considerable interest in differentiating organic from psychogenic erectile problems. Nocturnal penile tumescence testing and the Rigiscan device were commonly used although neither was infallible. Both of these tests were based on the assumption that men with psychological erectile problems would have normal erections during rapid eye movement sleep [9]. There was also considerable interest in determining the specific biological etiology to the problem [10]. The next advance was the introduction of the injection of vaso-active drugs into the corpus cavernosal tissue of smooth muscle. Drugs which relaxed smooth muscle such as phentolamine, papaverine, and prostaglandins were utilized [11]. In most cases, these interventions were limited to men diagnosed as having organic erectile problems. The situation changed rather dramatically after the introduction of sildenafil in the late 1990s. At this point, we had the introduction of a relatively safe reversible intervention which worked in psychogenic erectile problems as well as in erectile dysfunction associated with various medical disorders. The introduction of oral phosphodiesterare inhibitors (sildenafil, vardenafil, tadalafil) contributed to less concern about etiology, the assumption that most erectile dysfunction was organic in etiology, and a de-emphasis on psychological and interpersonal factors in erectile dysfunction [12]. Interestingly, most of the research concerning psychological factors in erectile dysfunction which has been published after the introduction of sildenafil and the other oral phosphodiesterase inhibitors has concerned the impact of successful pharmacological therapy on personal and interpersonal psychological factors such as self-esteem, self-confidence, and relationship satisfaction. Other studies have examined the role of psychological therapies as adjunctive therapies to pharmacotherapy [13].

Clinical Trial Criteria

The absence of a universally accepted operational definition of erectile dysfunction is evident in the

clinical trial literature. In clinical trials of erectile dysfunction, varying definitions of severity and duration were employed. Some trials required the persistence of a problem for 3 months [14] whereas others required a duration of 6 months [15]. Similarly varying definitions of erectile dysfunction were employed ranging from inability to sustain and obtain an erection [15] to consistent change in quality of erections [14]. Some trials included men with both mild and severe erectile dysfunction in the same trials [16]. Some trials required men to have erectile failure at least 50% of the time [17]. In some trials, subjects achieving adequate erections 75% of occasions were excluded from trials [18]. Severity of erectile problems was assessed by a questionnaire which had questions concerning obtaining and maintaining erections and confidence regarding erectile function. Subjects were then allocated into levels of severity by score on this questionnaire [19]. Most clinical trials were focused on heterosexual men, which may limit extrapolation to other populations.

Criteria Utilized in Epidemiological Studies

In spite of the massive increase in the literature on the treatment of erectile dysfunction since the late 1990s, there is relatively little literature concerning specification of severity or duration criteria for the diagnosis of erectile dysfunction. Epidemiological estimates of the prevalence of erectile dysfunction have varied depending on methodology and definitions employed in the various survey [20–23]. For example, studies have varied widely in the instruments utilized to measure erectile dysfunction. Some have utilized questions based on the National Institutes of Health consensus criteria [24] whereas others have employed standardized questionnaires [25], questions concerning degrees of rigidity and/or severity ratings [25–29]. Some studies did not specify the duration of the complaint whereas others specified 1, 3, or 6 months duration of complaints to be considered as erectile dysfunction [22]. Very few studies have examined how many cases of erectile dysfunction resolve without medical intervention. Schouten et al. [30] studied the incident rates of erectile dysfunction in a Dutch population followed for 2 and then 4 years. They noted a decrease in incidence rates at 2 and 4 years follow-up which "seems to suggest that that in some cases that erectile dysfunction is a self-limiting disease" [30]. Mercer et al. [31] in a study of sexual problems in a stratified sample of men and women aged 16–44, found that the prevalence of erectile dysfunction lasting for at least 1 month in the previous year was 5.8%. However, only 0.8% reported erectile problems lasting for as long as 6 months. Clearly, duration criteria could have a huge influence on how often the diagnosis is made. Studies also varied widely in the severity criteria utilized to define erectile dysfunction—e.g., some studies counted men with occasional erectile problems together with men having frequent problems together as having erectile dysfunction whereas other studies defined significant erectile dysfunction as severely reduced rigidity or no erections. If one then adds the criteria of whether or not the man is distressed by this erectile problems, the prevalence figures change again as not all men with significant erectile dysfunction are distressed by their difficulty [26,30]. Another example of how severity criteria can influence prevalence estimates can be found in the Global Study of Sexual Attitudes and Behavior [32,33]. For example, this study found that the overall prevalence of erectile dysfunction for men in the non-European West was 18.8%. However, only 3.5% reported this to be a frequent problem whereas 8.5% and 6.6% reported this to be an occasional or periodic problem. Clearly, different specifications of the severity of the problem will dramatically influence the frequency with which this syndrome is diagnosed.

Measurement of Erectile Function

A questionnaire known as the International Index of Erectile Function (IIEF) has become the standard instrument employed in clinical trials of pharmacological agents to treat erectile dysfunction [34]. This instrument has been shown to have excellent reliability as well as good concurrent, convergent, and discriminant validity. This instrument has five separate domains. The erectile function domain in the IIEF contains six separate questions. Each question is answered on 1–5 Likert scale. The questionnaire was originally standardized comparing scores of 111 men in clinical trials to treat erectile dysfunction with the scores of 109 age matched controls without symptoms of erectile dysfunction. A subsequent study of 37 patients with erectile dysfunction of multiple etiologies and 21 age matched controls was used to evaluate the construct validity and test–retest reliability of the instrument. Further statistical procedures generated a cutoff score of 25 or less as indicating erectile dysfunction. The choice of

cutoff score is influenced by how important misclassifying a person with erectile dysfunction is relative to the importance of misclassifying someone without erectile dysfunction [35,36]. Although this instrument has obvious strengths as an outcome measure in clinical trials, one can question whether the cutoff of 25 or less adequately distinguishes men with erectile dysfunction from normals. For example, a man who answers most of the time he obtains erections, that they are firm enough for penetration most of the time, that they were maintained most of the time, that they were only slightly difficult to maintain, and that he had high confidence in his ability to get and maintain an erection would get a score of a 24, placing him in the erectile dysfunction group. Another way of addressing the same issue is to note that the mean score on the IIFE erectile function domain for normals was 28.14 with a standard deviation of 3.31. Thus, a score only one standard deviation from the mean normal score would place an individual in the erectile dysfunction group. It should be noted that the IIEF only questions activity in the past 4 weeks. Subsequent studies have indicated cutoff for degree of severity of the problem [37] and the development of a 5-item Sexual Health Inventory named the SHIM [38,39]. Research instruments for the diagnosis and treatment of erectile dysfunction have recently been reviewed [40–42]. The IIEF clearly deserves use as a quantitative measure of erectile function. However, one can certainly question whether its cutoff score clearly distinguished between men with erectile dysfunction and normals who have minor fluctuations in function associated with life stress.

Another measure of erectile function is the erectile hardness grading scale which has been employed in many clinical trials [43,44]. This system employs a 4-point scale: grade one indicates an increase in penile size but no hardness; grade 2 indicates a slightly hard erection but not sufficient for intercourse; grade 3 indicates an erection hard enough for penetration but not fully rigid; grade 4 indicates a fully hard and rigid erection. This measure correlates with the IIEF and is highly related to patient satisfaction in clinical trials.

Most clinicians in sexual medicine have had encounters with young men who seek treatment thinking that their normal erections are not sufficiently turgid. On the other hand, there is some evidence, at least in men over 50 years old, that the report that one's erections have decreased turgidity may be an early marker for cardiovascular disease. In the study of 50- to 75-year-old men in a population study in Krimpen (a Dutch municipality near Amsterdam), a relationship was found between report of reduced erectile turgidity and subsequent acute myocardial infarction, cerebral vascular incident or sudden death [45]. Although severely reduced turgidity was a stronger predictor of future cardiovascular disease than simply reduced turgidity, both were significant risk factors.

Etiological Considerations

As mentioned previously, there has been little investigation regarding differentiation of psychogenic from biogenic erectile dysfunction. Since the advent of oral vasoactive agents, there is frequently an assumption that the majority of cases are organically based and may represent endothelial dysfunction. Upon identifying an organic abnormality, many clinicians assume that the organic problem identified is responsible for the erectile dysfunction although the presence of a disease possibly linked to erectile dysfunction does not confirm a causal relationship. For example, a man with diabetes mellitus can still have erectile problems secondary to psychological reasons [46].

Consideration of etiological factors is important as erectile dysfunction entirely explained by organic factors would not receive the psychiatric diagnosis of erectile disorder. A psychiatric diagnosis of erectile dysfunction by convention would be used for cases suspected of having psychological components in the etiology or maintenance of the disorder or in idiopathic cases. There is reason to suspect that psychological factors are involved in many more cases of erectile dysfunction than commonly assumed. First, there are high discontinuation rates in the use of phosphodiesterase inhibitors which appear to be related at least in part to psychological factors [47]. Counseling combined with medication adjustment has been found to have a positive effect on outcome in cases of medication non-compliance [48]. A number of studies have shown that the combination of psychological interventions with pharmacotherapy improves outcomes over that obtained with pharmacotherapy alone [49,50]. These findings reinforce the admonition by Riley and Riley that clinicians should be hesitant to assume that cases with organic components are totally biogenic. Anxiety, depression, distractibility, stress, and relationship deterioration can cause erectile dysfunction in isolation or in combination with organic factors. In many cases, erectile dysfunction may result from the interactive

and additive effects of biological, psychological, lifestyle, and social influences [51].

Proposed Criteria

There is minimal evidence available to specify duration and severity criteria to establish the diagnosis of erectile dysfunction. From this brief literature review, it is clear that various definitions have been employed.

One purpose of a definition should be to discriminate between a sexual disorder meriting intervention and between normal variations in sexual function. The other is to define homogenous groups for research.

Lewis et al. [20] advocate the use of a 3-month duration criteria for the diagnosis of erectile dysfunction but did not provide any data to substantiate this proposal. In view of the finding by Mercer that erectile problems of 6 months duration are much less frequent than those lasting only 1 month, it would seem logical to require 6-month duration prior to making a diagnosis. Given the marked difference in frequency between those rating erectile problems as frequent, periodic or occasional, one could argue that the requirement of erectile problems to at least be frequent. This distinction might best distinguish between men with fluctuations in normal function and those with a diagnosable sexual dysfunction. Frequent could arbitrarily be set as 75% of occasions.

Thus the proposed criteria are failure to obtain and/or maintain an erection until completion of the sexual act on 75% of attempts at sexual activity or a marked decrease in turgidity for at least a 6-month duration. An exception to the duration criteria would be made for instances in which there are a clear and immediate cause for the onset of erectile dysfunction such as interruption of innervation to the erectile tissue (such as surgical or accidental injury).

The DSM IV TR specifies the need for subtype diagnoses. These subtypes were lifelong vs. acquired; generalized vs. situational; and due to psychological factors vs. due to combined factors. As mentioned previously, the etiology may be clear in certain cases, suspected in others and wrongly attributed in others. The requirement of etiological subtyping in certain cases may force a clinician to make an attribution which is poorly grounded in fact.

To avoid the issue of forcing the clinician to specify an etiological diagnosis, it is recommended that associated features be specified. Listing of associated features avoids premature designation of etiology while still facilitating acquisition of information concerning co-morbid conditions. For example, one might specify other conditions of the patient which are known or suspected to be associated with erectile dysfunction. Examples of psychological factors would be infidelity by partner, recent divorce, and low attraction to current partner. Examples of medical factors might be substance abuse and borderline diabetes.

DSM IV TR lists criterion B (the disturbance causes marked distress or interpersonal difficulty) as one of the criteria necessary to diagnose erectile dysfunction. It is recommended that criterion B be deleted. The definition of erectile dysfunction would be as specified previously. However, for the diagnosis to reach clinical significance, it should cause distress to the individual. The separation of the diagnostic criteria from actual clinical diagnosis should facilitate research. In other words, the actual phenomenon of decreased ability to obtain and maintain erections would be the entity to be studied. Clearly, treatment would be appropriate only for those distressed by the problem. It is suggested that the term "marked distress" be eliminated as it has been subject to varying interpretations. Instruments specifically designed to measure distress have been employed in clinical trials because of the definition in DSM IV TR. The use of the term "marked distress "thus appears to have added an unnecessary complication to the clinical diagnosis of erectile dysfunction. The criteria of causing interpersonal difficulty appear redundant and unnecessary. If the man seeks treatment because of interpersonal difficulty associated with his erectile problems, this would appear to be prima facia evidence of distress. If the man comes for treatment only because his partner is distressed and the man is completely undisturbed by the sexual difficulty, one could easily argue that the problem should be diagnosed as interpersonal conflict and not erectile dysfunction. It is recommended that the term "marked distress" be replaced with the term "emotional discomfort."

As well as by using commonly employed instruments such as the IIEF and SHIM, treatment progress could also be monitored by grading erectile dysfunction could be graded on a 4-point scale: inability to obtain of maintain erections on 75% or more of sexual attempts, failure on approximately 50% of occasions, failure less than 50% of the time, rare or never failures.

At this point, it is important that these suggested revisions in criteria be reviewed by clinicians and

clinical investigators and modified if necessary. Although these criteria are intended for the DSM V, they may influence criteria employed by other disciplines.

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Conflict of Interest: None.

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Comments on "Considerations for Diagnostic Criteria for Erectile Dysfunction in DSM-V"

The definition of erectile dysfunction has evolved significantly over the last several decades with an increased understanding of the pathophysiology of this condition, as well as with major advances in therapeutic options. In 1980, the American Psychiatry Association identified sexual dysfunctions as a distinct syndrome in the Diagnostic and Statistical Manual of Mental Disorders III (DSM III). DSM-IV was published in 1994 and the revised and presently used DSM-IV-TR (text revision) was released in 2000. While working groups and task forces has been ongoing since 1999, the next version DSM-V will be published in 2012 [1].

The present DSM-IV definition has been criticized as lacking specificity regarding the duration and severity of the erectile dysfunction, as well as not clearly defining the relational context of the problem [2,3]. For example, based on DSM-IV, it is unclear what is meant by "persistent or recurrent" in the context of symptomatology. Should there be a difference in categorization of a man who has erection difficulties for 1 month or 1 year, or for 25% or 75% of failure at attaining or maintaining an erection? Does he have erectile dysfunction if he is not distressed or have an interpersonal difficulty as a result?

In this month's *Journal of Sexual Medicine* article, the author has proposed that revisions for DSM-V criteria include that erectile dysfunction represents a "failure to obtain and/or maintain an erection on 75% of attempts at sexual activity or a marked decrease in turgidity for at least a six month duration." While these suggestions appear reasonable, ultimately, the designation of specific criteria will be by committee discussion and not based on tested outcome-oriented data. More specific criteria are necessary and will be welcomed. It should be remembered that these criteria may also be used by insurance companies to determine eligibility for coverage for benefits related to erectile dysfunction.

Other professional groups have working definitions of erectile dysfunction. The National Institutes of Health (NIH) Consensus Development Conference on Impotence (December 7–9, 1992) defined impotence as "male erectile dysfunction, that is, the inability to achieve or maintain an erection sufficient for satisfactory sexual performance" [4]. The third International Consultation on Sexual Medicine will also publish revised definitions in early 2010. DSM-V is highly relevant, especially in the United States, because of its recognition as a well-recognized classification system in concert with International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) codes for billing and coding purposes.

The importance of creating more precise criteria for DSM-V is the opportunity to adapt clinically meaningful operational criteria that will facilitate clinical research, treatment algorithms and, most importantly, the treatment of the patient with erectile dysfunction [5]. The challenge of revising these criteria in a working panel format with group consensus reminds me of the fable of the six blind men trying to describe an elephant. Each man felt a different part of this large animal. When comparing their descriptions, they had a complete lack of consensus about what an elephant really represented. Reality may be viewed differently depending upon one's perspective, suggesting that what seems an absolute truth may be relative.

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The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. It is used in the United States and elsewhere by clinicians, researchers, drug regulation agencies, health insurance companies, pharmaceutical companies, and policy makers. The authors of this article summarize some of the issues surrounding the diagnostic criteria for erectile dysfunction, with proposals for a revision of these criteria to be included in the next version of DSM (DSM-V), which is due to be published in 2012. The chief alterations from the current version that are being proposed are the introduction of a minimum duration of symptoms of 6 months and the introduction of a minimum frequency of at least 75% of sexual attempts. There is also removal of the need for there to be patient "distress" present for the diagnosis to be possible. However, if distress is present, then the diagnosis is deemed to be of clinical significance.

It is important to consider the purpose of diagnostic criteria for erectile dysfunction. They should serve to aid clinical research, to aid epidemiological studies and to "discriminate between a disorder meriting intervention and between normal variations in sexual function". The danger is, of course, that reimbursement may follow diagnosis, and if the diagnostic criteria are too restrictive, then it may be that appropriate treatment is restricted as a consequence.

It is in relation to this latter point that the current proposals raise some concerns. For epidemiological purposes, a defined duration of symptoms seems desirable and the 2nd International Consultation on Sexual Dysfunctions suggested a minimum duration of 3 months [6]. While this current proposal suggests 6 months, a caveat is given whereby if there is a clear acute cause (such as radical prostatectomy) then the restriction of 6 months duration is unnecessary. The timeline of 6 months is justified largely on the basis of a single study from the United Kingdom which demonstrated that by putting a 6-month time limit onto the diagnostic criteria, the incidence of erectile dysfunction fell from 5.8% to 0.8% [7]. One might ask whether for those patients with temporary erectile dysfunction lasting less than 6 months, the experience was any less distressing than those with permanent symptoms and further whether this restriction indeed "discriminate(s) between a disorder meriting intervention and between normal variations in sexual function".

Similarly, the arbitrary way whereby the diagnosis can only be used in patients with an inability to attain or maintain an erection on more than 75% of occasions is acknowledged by the authors. There might again be reservations regarding this criterion, given the arbitrary way in which it was chosen and the situational nature of some men's symptoms.

With these caveats, the arguments presented in favor of a definition that aids epidemiological and clinical research are convincing, although it is to be hoped that this article represents the beginning of that process and not the end. The trick will be to reach a definition which provides the accuracy that researchers need without being at the same time so restrictive that it denies treatment to deserving patients.

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The authors have presented a logical, historic description of the previous criteria for the diagnosis of erectile dysfunction, and the present context for the criteria to be considered for DSM V.

In addition to the proposed criteria for diagnosing erectile dysfunction, I would propose three core concepts in understanding, assessing, and treating erectile dysfunction [8]:

1. Careful examination of the three factors contributing to erectile dysfunction:
   A. Biological/medical factors which inhibit functional response as well as those which can enhance erectile response
   B. Psychological factors which inhibit and enhance erectile response
   C. Relational/social factors which inhibit and enhance erectile response
2. The crucial importance of a comprehensive, science-based approach to sexual function and dysfunction rather than emphasizing an individual, biomedical approach to erectile dysfunction [9].
3. Establishing a variable, flexible Good Enough Sex approach to erectile function and dysfunction rather than the traditional male control and predictability criterion of intercourse performance as a pass-fail test [10].

In assessment, treatment, and relapse prevention of erectile dysfunction, a major issue is whether the focus is on individual sex performance or sexual dysfunction as an interpersonal sexual problem [11]. Rather than discussions of "distress" to the individual, the psychosocial reality is that at its core the role and meaning of sexual function and dysfunction is interpersonal (relational).

The psychosocial emphasis is even more crucial in considering the role of establishing criteria for a diagnosable sexual dysfunction. Is the proposed criterion of successful intercourse occurring on 75% of encounters valid and useful? McCarthy and Fucito [12] have argued that in treatment and relapse prevention of erectile dysfunction, the core issue is not percentage of successful intercourse, whether or not facilitated by pro-erection medications or erectile aides, but rather the couple's acceptance of the Good Enough Sex approach with a focus on desire, pleasure, and satisfaction. If the man (as well as DSM and the medical profession) continues to be controlled by the rigid measure of predictable erections and intercourse as a pass-fail test, then

male and couple sexuality will continue to be plagued by anticipatory and performance anxiety which eventually leads to sexual avoidance and a non-sexual relationship.

In establishing diagnostic criteria for understanding, assessing, treating, and relapse prevention of erectile dysfunction, the comprehensive biopsychosocial model is necessary with a focus on sexuality as an interpersonal process of sharing pleasure and eroticism rather than an individual performance test.

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The author addresses a number of shortcomings of the existing DSM-IV criteria for erectile dysfunction and makes recommendations for modifications to improve them. These suggested changes include the addition of a "frequency" as well as a "duration" component, modification of the subtypes (lifelong vs. acquired; generalized vs. situational) and elimination of the requirement for marked distress or interpersonal difficulty. Unfortunately, the rationale, the logic and the data offered to support these changes seem incomplete.

Data [13] suggest that there is a linear correlation between duration of ED, perceived severity, distress and treatment-seeking in men with ED, however, it would seem that the arbitrary values suggested of 6 months duration and failure on 75% of attempts are neither justified nor evidence based.

Regarding modification of the subtype criteria, the author notes the lack of specificity and utility of the existing categories. However, his suggestion to add other criteria ". . . . known or suspected to be associated with erectile dysfunction. . . . examples of psychological factors would be infidelity by partner, recent divorce, low attraction to current partner" would appear to be fraught with the same problems. Divorce from a hostile partner might just as easily contribute to improved erectile function and it is difficult to understand how a clinician could ascertain the degree of attraction to a current partner in a meaningful, let alone consistent or replicable way.

Then there is the bedeviling construct of "personal distress or interpersonal difficulties". While on the one hand, it can be argued that as these criteria have never been routinely utilized in clinical or epidemiological trials of ED, perhaps their inclusion should be abandoned. On the converse, it is hard to imagine the removal of these criteria for a sexual dysfunction in males as long as their inclusion remains a cornerstone of criteria proposed for sexual dysfunction in women [14]. Gender-based differences on this basis would be hard to defend, and either consistently applied or universally abandoned.

Last, but perhaps most troubling, the author suggests that the availability of oral vasoactive agents has led to ". . . an assumption that the majority of cases (sic) are organically based and may represent endothelial dysfunction." While it is reasonable to suggest that a majority of cases of ED entail some psychological component, I would argue that it is less the availability of drugs than an impressive body of evidence on erectile physiology that supports the assumption that the majority of cases of ED are organically based. And therein lays perhaps one of the greatest weaknesses of the current proposals. At the time DSM-IV was written, none of the sentinel work on nitric oxide [15], endothelial dysfunction [16,17] and their relationship to erectile dysfunction was known. There is now abundant evidence that the majority of men with ED have underlying vascular pathology that contributes to compromised erectile function. Evidence of the reverse, that they have a psychiatric dysfunction, is noticeably absent; the finding that counseling in conjunction with pharmacotherapy has been shown to improve outcomes in no way establishes psychogenic causality.

The DSM serves many important functions beyond a diagnostic manual for clinicians; it informs research decisions and determines reimbursement for many sexual medicine services. It could be argued that as regards ED, its function for the latter is more important than its utility to establish a diagnosis of ED, and in that context, the current proposal remains problematic.

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The discussions and revisions to diagnostic categories of the DSM V mark an exciting time for debate and dialog that will help shape the field of sexual medicine for years to come. Segraves in his article "Consideration for Diagnostic Criteria for Erectile Dysfunction in DSM V" highlights a number of concerns and difficulties when crafting these new diagnostic requirements for erectile dysfunction (ED). The author focuses on a number of

areas for discussion. These include duration, severity, specific subtypes of diagnosis, specification of an etiology of erectile dysfunction, and the need for marked distress or interpersonal difficulty as a criterion for diagnoses.

In discussing these areas of debate, I think it is important to keep in mind the multiple purposes of a DSM diagnosis. In addition to providing a concrete diagnosis, the DSM classification hopefully also helps facilitate communication between clinicians and guide treatment decisions [2]. When keeping in mind these multiple functions, in addition to basing our decisions on empirical data, it's obvious that healthy debate may not produce a group consensus. I focus this commentary of three specific aspects of the article. First, Segraves proposes a needed duration of 6 months before a diagnosis of erectile dysfunction could be given, and cite data in which the incidence of ED is unstable within 6 months of the first difficulties with erections. Others have argued that difficulties with erections need to persist for 3 months before a diagnosis [6]. Both seem too long for me. If part of the purpose of the DSM is to facilitate communication and treatment decisions, are clinicians realistically going to wait for duration of at least 3 months before they discuss treatment options with the patient? To compare this to the DSM diagnosis of depression, we know that some depression do mitigate over time, however, the DSM diagnosis for depression is structured around depressive symptoms for a 2-week period within the past month. It seems reasonable to use a similar timeline for ED. Second, I agree with the listing of associated features as opposed to defining an etiology. I specifically appreciate Segraves' discussion of the impact of psychological factors on ED and agree that "psychological factors are involved in many more cases of erectile dysfunction than commonly assumed" (p. 12 in manuscript). Additionally, I also agree with Segraves on the exclusion of distress as a necessary criterion for the diagnosis of ED. I prefer the structure of including this as a "specifier" as opposed to a criterion [18], although I disagree with Segraves' opinion that emotional distress and interpersonal difficulty are redundant. Certainly, if there is interpersonal difficulty caused by ED, it is also causing emotional discomfort, but emotional discomfort does not necessarily imply interpersonal distress. Again, if a DSM diagnosis is meant to facilitate clinician communication and guide treatment decisions, having information on both emotional discomfort and interpersonal distress would assist in clinical discussions and appropriate treatment planning.

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This consideration for the inclusion of diagnostic criteria for erectile dysfunction (ED) in the DSM V refocuses the need to specify the etiologic diagnosis—psychogenic versus organic—and concentrates on a clinical definition of ED and a noting of its associated comorbidities. This clinical diagnosis includes a specification of the duration of the ED, and the frequency. While rather arbitrarily assigning this clinical definition as follows: "a failure to obtain and/or maintain an erection until completion of the sexual act on 75% of attempts at sexual activity, or a marked decrease in turgidity for at least a six month duration." The only exception to this is where there is clear and immediate cause of the ED in the interruption of innervation to the erectile tissue such as prostate cancer surgery or accidental injury to the spinal cord.

In addition, it should be noted that in order for the diagnosis to reach clinical significance, it should cause distress to the individual. While this separation of diagnostic criteria from clinical criteria is relevant for research purposes, the inclusion of distress impacts a treatment decision. And the elimination of previous DSM IV criteria of "marked distress" should be welcomed as an opportunity to eliminate redundant and unnecessary criteria of a cause of interpersonal difficulty that is indeed difficult to measure. If a man seeks treatment for his ED, this should suffice for a level of distress to offer treatment.

As a clinician, I welcome these changes in the definition of ED. Having lived through the era of determining the cause of the ED at the initial presentation, psychogenic vs. organic, I have indeed found that in most cases ED is associated with a mixed confluence of signs and symptoms. In the era, prior to the release of PDE5-inhibitor therapy, it might have been vital to determine the exact etiology of ED for the single treatment of placement of a penile prosthesis is irreversible. However, this bias continues to the present day in the United States where we must code "organic impotence: ICD-9 Code 607.84" rather than "psychosexual dysfunction with inhibited sexual excitement: ICD-9 Code 302.72" to allow reimbursement from many insurers.

As we become more fluent with the pathophysiology of ED, we focus on the early presentation of a man's ED and its relevance to his vascular health. Since the text revision of the DSM IV TR 4th Edition, a large body of evidence has accumulated demonstrating that ED and cardiovascular disease share common risk factors such as diabetes mellitus, hypertension, smoking, dyslipidemia, and a sedentary lifestyle [19–23]. Because endothelial dysfunction is common in ED and these comorbidities, and because ED seems to occur prior to the onset of cardiovascular symptoms, recent studies have suggested that ED could be considered a potential marker for underlying vascular disease processes [19–26]. Therefore, early detection of ED may offer physicians a unique interventional opportunity to address underlying cardiovascular health concerns in men presenting with ED [19–23].

It may be that duration of erection, often noted in clinical practice as diminished rigidity or turgidity, is a sign of vascular health and therefore the first sign of endothelial cell impairment in the penile vasculature is the inability to sustain an erection. Perhaps the decreased ability to maintain an erection offers an earlier clue of this evolution. Both Miner [19] and Thompson [23] have noted a "window of opportunity" for identifying ED and its subsequent cardiac risk. Obviously, a larger "window" would be most desirable for the patient and provider. Is it possible that decreasing duration of erection is the noticeable manifestation of an evolving endothelial disease? Would the patient who states that his erections do not last as long as "they used to" be giving the provider a clue as to the worsening of his cardiovascular status?

Therefore, I applaud the author's proposal to refocus the discussion of "ED at the bedside" and thereby the clinical definition to include a discussion of failure to obtain or maintain, or diminished turgidity, for at least 6 months duration. This is a novel marker of a man's vascular health and a window of time to pursue and reverse comorbid risk factors.

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Diagnostic criteria for sexual disorders should be derived from the best available evidence. Unfortunately, the vast majority of recent research on ED has focused on treatment rather than diagnostic classification. A decline in attention to the etiological causes of ED is not surprising given the efficacy of oral pharmacotherapy for ED of all types [27]. Why delve deeply into causes when therapy will most likely be the same? Nevertheless, there is an obvious need for clear and accurate diagnostic criteria for clinical practice and research.

Unfortunately for the developers of diagnostic criteria for sexual problems, humans have an incredibly rich diversity of sexual practices. It is difficult to design a diagnosis that is all-inclusive. We are not aware of any objective data on the frequency or chronicity of problems that can reliably be used to predict sexual distress between persons. In our opinion, it is unclear whether or not such criteria can even exist. The proposed criteria for ED; "failure to obtain and/or maintain an erection until completion of the sexual act on 75% of attempts at sexual activity or a marked decrease in turgidity for at least a six month duration" are arbitrary. Why 75%? Why 6 months? What is "completion?" Such criteria inevitably reflect the biases and opinions of their creators. While one could use population data to construct a bell-curve of sexual activity/difficulty and classify those individuals with values outside of some range "abnormal", such criteria would easily misclassify many people.

The issue of age is another important concept; does age of the subject make a difference in who should or should not be diagnosed with ED? While changes in sexual function often accompany aging, in no sphere of medicine do we not strive to treat age-associated morbidities. Does a man with rigid erections 75% of the time who misses the 100% of his youth merit the diagnosis of ED? What diagnosis is more appropriate in this case?

Inclusion of the distress criteria has been criticized in the past [18]. Distress is an important mediator of whether or not a man seeks treatment for ED; however, it is not a component of the physiological phenomenon of inability to attain a rigid erection. Nevertheless, we find substitution of the term "emotional discomfort" a relatively minor change that does not fundamentally alter the conceptual underpinnings of the DSM IV, and would recommend removal of this phraseology altogether.

The modern concept of ED as an organic phenomenon necessitates important qualifiers when making the diagnosis based on the psychologically based DSM. In our opinion, there is always a psychogenic component to ED. Fear of erectile

inability in the setting of having previously "failed" (for whatever reason) provokes significant anxiety, which in turn will further compromise erectile function, likely though sympathetic nervous system activation and/or inhibition of NO release.

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Since 1987 with the third revision of DSM III [28], there have been many attempts to find a better definition of erectile dysfunction. However, the lack of a universal definition has created many challenges.

Epidemiological studies based in different definitions and methodological tools have shown prevalence of ED that range from 15% to 55% [29–31]. This creates unrealistic expectations on the number of patients who must be seen at the medical offices (and did not) and the ED drugs sales.

Thus, it is very important to have a standard, universal definition of ED. But we should differentiate between the definition of the disease and the ones that are used on research.

This proposed criteria "failure to obtain and/or maintain an erection until completion of the sexual act on 75% of attempts at sexual activity or a marked decrease in turgidity for at least a six month duration. An exception to the duration criteria would be made for instances in which there are a clear and immediate cause for the onset of erectile dysfunction such as interruption of innervation to the erectile tissue (such as surgical or accidental injury)" could be used.

But why 75% and not 50% of attempts? A man who had tried twice and did not get an erection and did not try any other attempt in the last 2 months is not a patient with ED? A man who fails in some attempts but is able to have a good erection in other situations, which has a clear performance of anxiety, considers him as having ED. I have a patient who has a great performance when he takes a phosphodiesterase type V inhibitor; he told me that every time he takes the pill it reminds him that he "is impotent".

I consider that any man who goes to a doctor because he has not been able to obtain or maintain an erection until completion of the intercourse in any period of time has ED. For me, that is the definition of the disease. It is a good model to add the medical situations that can be the cause of the dysfunction and "unknown" should be one of the options.

For research purposes, I agree that we need to have more homogeneous groups and we need a more strict definitions; I accept a failure on 50% or 75% of the intercourses in the last 6 months as a good criteria.

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After two international consensus conferences on sexual medicine, the definition of erectile dysfunction (ED) is well accepted as a male arousal disorder with consistent or recurrent inability of a man to attain and/or maintain penile erection sufficient for sexual activity[1] [32]. The third international consensus conference on sexual medicine was held in Paris in July 2009 and the committees are still working on the final version of the consensus. It is believed that there will be no change regarding the definition of ED. The committee to define ED believes that 3 months minimal duration of the condition is required to establish the diagnosis except in instances that clear and immediate causes for the onset of the condition are known such as traumatic or surgically induced injury to the cavernosal nerves. The current proposed DSM V definition for male ED suggests a 6-month duration before making the diagnosis. Currently, there is no good evidence to support the use of 3-month or 6-month duration. The suggestion of 6-month duration is based on one study that Mercer et al. found erectile problems of 6 months duration are much less frequent than those lasting only 1 month [7]. Readers need to realize that the study from Mercer et al. was a stratified probability sample survey in men and women aged 16–44 years, not a prospective study to look at the natural evolution of erectile problem in an aged population where ED is more common. It is important to set a reasonable duration of a condition before making the diagnosis because either premature diagnosis or delayed diagnosis may have psychological impact on patients and possibly cause interpersonal conflict. A third party payer may also look at this definition and deny coverage for patients suffering from ED less than 6 months. If this definition is to be tested in the clinical practice, it may also have an impact on how we are interpreting the currently validated instrument questionnaires such as IIEF and SHIM because these instruments only question sexual activities in the past 4 weeks. Introduction of frequency of erectile problem during sexual activity in

this DSM V definition is also a very important step to complete the definition of ED even though erectile failure on 75% of attempts is arbitrarily set as the criteria. We may not necessarily agree with it because we do not know what frequency of the erectile problem will cause significant distress to patients and their partners. Hopefully, further evidence-based research will answer this question in the years to come. In this proposed DSM V definition, the marked decrease in turgidity was also proposed as the criteria for diagnosis. Again, lack of specificity of "marked decrease in turgidity" is obvious and readers may consider using an erectile hardness grading scale of grade 3 or less to quantify the "marked decrease in turgidity" when testing this definition.

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The present manuscript aimed to introduce a modified, improved definition for ED.

Today, ED is clearly recognized as a disease of organic etiology yet it may certainly be associated with psychological factors (anxiety, depression, distractibility, stress, etc.) and in the minority of cases may be accepted as purely psychogenic. Consequently, classifying ED in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) in the first place is questionable. A discussion on a better framework is mandatory.

Undoubtedly, the only reason for changing any old definition is the need to adapt it to new discoveries and clinical needs.

The proposed criteria for changing the definition are not clearly outlined in this manuscript. Definitions are necessary for many reasons, mainly for research purposes, diagnosis or for treatment decision.

We would suggest focusing on what we believe is the main need for a change in the definition which is treatment goals, because oral therapy has dramatically affected the whole outlook on ED. In today's practice, intervention is offered not only to ED patients but also to normally functioning males for sexual enhancement. As previously published, subjects with mild or normal erectile function can clearly benefit from treatment [33]. Undoubtedly, this trend will expand with the introduction of even safer and more effective treatment modalities. Therefore, there is no need to discriminate anymore between those meriting intervention and those with a normal variation in sexual function as suggested by the authors.

Moreover, in the case of ED, the dependence on the partner is a crucial and unique aspect of this specific condition. The importance the partner has on success of the intervention has recently been recognized and the partner factor has become an integral part for assessing treatment outcome [34]. Regarding other issues raised by the authors, in our view, duration, frequency, and severity of the problem are secondary factors in treatment considerations and are probably unnecessary.

The best and simplest way to overcome some of the problematic issues raised in this manuscript is first to change the nomenclature and then to modify the definition itself. We suggest a different nomenclature: "Sexual Difficulty" (SEDIF) for all types of "psychogenic ED" or for ED combined dominantly with psychological factors, as opposed to Erectile Dysfunction (ED) which would be left for mainly organic etiology. For the sake of simplicity and considering all the above-mentioned factors, we suggest to leave the first two criteria of the DSM IV as they are, and to discard the third criteria for ED *(the 3rd criteria for ED [psychogenic] is per exclusion of a medical condition)*. By doing so, the basic definition remains adequate for both organic and psychogenic etiology.

The partner factor should then be included but requires a deep discussion before reaching a consensus in this regard.

Accomplishing a new definition for ED is challenging, but keeping it practical for clinical use is essential if we want it to be vastly accepted by clinicians.

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The past three decades have witnessed significant progress in the field of erectile dysfunction (ED). Advances in the understanding of the physiology of erectile function and pathophysiology of ED have resulted in improved management, both diagnostic and therapeutic, of this highly prevalent sexual disorder.

The 1993 National Institute of Health (NIH) definition of ED moved nomenclature from the much-maligned term "impotence" to erectile dysfunction [35]. This universally accepted definition of ED as "*the persistent inability to achieve or maintain an erection sufficient for satisfactory sexual perfor-*

mance", serves as the standard definition for contemporary clinical and research settings when evaluating compromised erectile function. However, contemporary terminology related to ED does contain certain omissions, and inconsistencies remain across different health care practitioner groups treating erectile dysfunction through the use of differing definitions. Therefore, it is also important to acknowledge, as the authors did throughout their comprehensive review, that several published clinical trials after 1993 did not use the NIH definition when evaluating ED, undoubtedly making data interpretation and further comparison to other trials challenging.

Six months of compromised function as a "duration" criteria prior to making a diagnosis of ED has been suggested previously; this is particularly important during design of clinical trials. However, incorporating such standards into clinical practice may not be in the patient's best interest, as there is scant evidence to show that this arbitrary time frame is required prior to successful ED treatment. For example, a healthy 60-year-old man complaining of ED for the past 4 months could be counseled that it is too early to initiate treatment, and management would be postponed for 2 months or longer. Also, as recognized by the authors, there are instances where ED develops almost immediately, e.g., post-radical prostatectomy, and management of ED can, and often does, follow with minimal or no delay. Furthermore, men in specific situations where psychogenic ED is more likely, such as "honeymoon ED", should have the option to be treated expediently as delays may have severe consequences on their marital and social lives. From a real-life practice perspective, there is little evidence that expanded duration criteria translate into optimized patient management when metrics of function as measured by the IIEF (International Index of Erectile Function) or SHIM (Sexual Health Inventory of Men) or a return to normal erectile function (with or without pharmaceutical intervention) are used as end points [36,37].

The proposal of classifying the severity of ED based on the frequency of experiencing poor erection during sexual intercourses is largely subjective and care must be taken before implementing such changes into clinical practice with little to no evidence for a 75% cut-off of "normal" fluctuation in erectile function. As the practice of sexual medicine has evolved, progress in health care delivery has been directly attributable to evidence obtained for specific diagnostic criteria, treatment options, etc. Without correlation to underlying disease and measurable outcomes, and in the absence of population based, longitudinal studies of erectile function with this question as a primary end point, the cut-off assumptions as proposed are very difficult to confirm and may not allow for meaningful improvement upon our ability to treat ED. Simply put, is it normal to fail, achieve, or maintain an erection sufficient for satisfactory sexual performance *5 out of 20 times*? Without further study, achieving a balance between medicalizing "normal" function vs. under-treating men and their partners with ED based on the proposed adjustment to diagnostic criteria is improbable.

"Marked distress" is to be removed from the DSM IV definition of ED and replaced by the clearer and more accurate term "emotional discomfort"; the rationale for this is clearly outlined in the review. On the other hand, monitoring treatment progress on the proposed 4-point scale based on the fraction of successful sexual attempts is not validated as of yet, and as compared to the IIEF, SHIM or erection hardness score (even with inherent limitations to these measures), appears limited in its utility and falls outside of the scope of evidence-based clinical practice [38,39].

In conclusion, the proposed modifications address many of the weaknesses present in the DSM IV definition of ED. However, care must be taken before changing contemporary standards and the evidence for such should be taken from the best available data, and if lacking, from new well-designed studies addressing these shortcomings. Practitioners in the field of sexual medicine look forward to the new revised DSM V definition of ED, in that it will be more accurate, comprehensive and positively impact patient care.

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It seems that many of us feel that the diagnostic criteria for sexual dysfunction(s) should be changed, though we have a hard time clarifying why and how. Is it because the next edition of the Diagnostic and Statistical Manual Disorders (DSM) is "due", or is there justifiable dissatisfaction with the standing criteria and an intrinsic need of the field to get something new, better, more valid and more reliable? Though my colleagues and I [3,5,40] have advocated for the

changes, I do not have a clear answer. Nevertheless, the arrival of the new criteria in a few years is a matter of fact and thus the main question is what we are going to get. The criteria of some of the sexual dysfunctions, especially in the area of female sexual dysfunction, will probably be revised more substantially due to various new concepts of female sexuality and female sexual dysfunction [14]. The criteria for male sexual dysfunctions, including erectile dysfunction (ED) will probably undergo less substantial change (whatever "substantial" is). The article by Segraves proposes new criteria for ED. The changes are not drastic and are rooted in the standing criteria, trying to address some of their flaws. Interestingly, the article mentions that the full impact of PDE-5 inhibitors on the diagnostic considerations had not been fully appreciated. While I agree with this statement, I would dare to add that the advent of PDE-5 inhibitors actually hindered our quest for better diagnostic criteria for ED. The treatment of any erectile dysfunction or problem, without consideration of the cause or meeting any diagnostic criteria is very "easy" now—PDE-5 inhibitors seem to work for all of them. Thus, clinicians may falsely believe that they do not need to think very clearly about the diagnosis. In addition, the diagnosis of ED seems "so easy" as the problem is "so visible."

However, as many argue, more specific diagnostic criteria of ED are needed for various reasons. I would like to comment briefly on what the proposed criteria address and what they do not address.

What the criteria do address: this proposal addresses three major aspects: duration, severity, and distress. I believe that introducing the duration criterion (6 months) is the least controversial, and most acceptable issue, and making this set of diagnostic criteria more consistent with the rest of the DSM as I pointed out previously [40]. The issue of severity is a bit more complicated as quantification is complicated and difficult. Nevertheless, the 4-point scale (75%, 50%, 25% and rarely or never) may be the step in the right direction as long as it provides some flexibility. This criterion is going to be still quite dependent on the clinician's judgment, but provides for some quantification. The validity and reliability of this quantification needs to be properly tested. The issue of including or abandoning distress as a diagnostic criterion is the most complicated one. I am not sure whether replacing the term "marked distress" with "emotional discomfort" is the solution. As I pointed out previously [40], there are three important points related to using the distress as a diagnostic criterion: (i) we need to better define what the distress is (worry?, interpersonal difficulty?); (ii) how to quantify it (another 4-point scale?); and (iii) how to classify those individuals who meet all other criteria of sexual dysfunction but are not distressed. The quantification of distress and severity would bring us closer to the dimensional concept of the diagnostic criteria proposed by many.

What the criteria do not address: the proposed criteria do not address an important problem known to many clinicians—transient, situation, or psychological/interpersonal issues dependent ED (e.g., during marital discord, presence of children in the same room, etc.). I believe that this issue could be resolved by introducing a new diagnostic entity: adjustment disorder with disturbance of sexual function (specifically, erection). Introducing this entity would be helpful in guiding physicians to look more specifically for a presumptive cause of ED that maybe alleviated by psychological or behavioral or psychoeducational interventions. Furthermore, the proposed criteria also do not fully address the frequently entertained dimensional approach. Fagan [41] has skillfully argued for using a variation of this approach by implementing the four perspectives—the disease, the dimension, the behavior and the life story ones. The standing and proposed criteria, being atheoretical and descriptive, also understandably do not address causality. Finally, the standing and proposed criteria do not address asexuality, normal variation in erection and the decline in erectile function associated with aging (up to what age do we expect full erectile function from the point of reproduction capability, etc.). These and many other issues will hopefully be the center of our attention and research in the future.

Finally, I would like to point out a very important weakness or flaw of the entire field of sexual medicine: interestingly, our field has never developed a solid, clinically useful, validated, reliable, and widely used diagnostic instrument for sexual dysfunctions (including ED) akin to the Structured Clinical Interview for DSM Disorders (SCID). I believe that the development of such an instrument together with good field trials testing its characteristics/qualities would be a much more important next task in our quest for better diagnostic criteria than the next version of the criteria themselves.

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