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The DSM Diagnostic Criteria for Sexual Aversion Disorder

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Abstract Sexual Aversion Disorder (SAD) is one of two Sexual Desire Disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and is defined as a "persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner" which causes distress or interpersonal difficulty. This paper reviews the short history of the diagnosis of SAD as well as the existing literature on its prevalence and etiology. Kaplan (1987) emphasized the phobic qualities of individuals with SAD who are highly avoidant of all forms of sexual contact. Much has also been written about the overlap between SAD and panic states, and the more obvious similarities between SAD and anxiety as opposed to sexual desire are described. There has been very little new published data on SAD since the publication of DSM-IV and the precise prevalence remains unknown. This paper critiques the placement of SAD as a Sexual Dysfunction and argues that it might more appropriately be placed within the Specific Phobia grouping as an Anxiety Disorder.

Keywords Sexual Aversion Disorder · Sexual phobia · Sexual avoidance · DSM-IV-TR · DSM-V

Introduction

In the book, *Sexual Aversion, Sexual Phobias, and Panic Disorder,* published in the same year that DSM-III-R (American Psychiatric Association, 1987) was released, Kaplan (1987) remarked that "sexual panic states have received surprisingly little professional attention, and students in the field are hard put to find literature on this topic" (p. 3). The state of the science some 20-plus years later has not changed much and there are still little empirical data on Sexual Aversion Disorder (SAD). SAD is one of two Sexual Desire Disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000) (the other one being Hypoactive Sexual Desire Disorder (HSDD)), and the most recent addition to the list of Sexual Dysfunctions in the DSM (American Psychiatric Association, 1987). Relative to the research done on HSDD, much less is known about the prevalence, etiology, and treatment of SAD.

Diagnosis

The original diagnostic criteria for SAD (302.79) required a "persistent or recurrent extreme aversion to, and avoidance of, all or almost all, genital sexual contact with a sexual partner" and that this symptom did not occur "during the course of another Axis I disorder (other than a Sexual Dysfunction), such as Major Depression" (American Psychiatric Association, 1987, p. 293).

In the DSM-IV-TR (American Psychiatric Association, 2000), Criterion A did not change from that listed in the DSM-III-R. The only addition to the diagnostic criteria was Criterion B–that the disturbance cause marked distress or interpersonal difficulty (Table 1). The DSM-IV-TR text indicates that anxiety, fear, or disgust when confronted with a sexual opportunity are features of SAD. Moreover, the scope of the sexual stimuli producing the aversion can range from a specific aspect of the sexual encounter (e.g., genital secretions) to any and all sexual stimuli (including kissing, touching, and hugging). The text goes on to describe symptoms of anxiety (e.g., panic attacks) and avoidance behavior as signs of severe SAD.

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Table 1 DSM-IV-TR diagnostic criteria for Sexual Aversion Disorder (302.79)

A. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner
B. The disturbance causes marked distress or interpersonal difficulty
C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction)
Specify type
Lifelong type
Acquired type
Specify type
Generalized type
Situational type
Specify
Due to psychological factors
Due to combined factors

Sexual aversion was described by Kaplan as being persistent and irrational as well as ego-dystonic, with the phobic avoidance causing significant distress to the individual. She also indicated that it may or may not be co-morbid with other sexual dysfunctions. Kaplan described total and situational forms of sexual aversion: total aversion involved any and all erotic sensations, feelings, thoughts, and opportunities whereas situational was limited to a specific aspect of sex (e.g., genitalia, being penetrated, fantasies, orgasm, oral sex, etc.). Kaplan noted an interesting feature of individuals with situational sexual aversion in that they could enjoy many aspects of sexual activity as long as avoidance of their circumscribed phobic stimulus could be maintained. Kaplan also described enormous variability across individuals with sexual aversion in their willingness to be sexually active, with some who were able to push past their reluctance of sex and, once engaging in sexual activity, to experience satisfaction. Others, however, were more severely phobic such that they could not feel any erotic sensations. Some of these individuals also experience panic attacks ("discrete period of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom" [American Psychiatric Association, 2000] with symptoms of autonomic activation). What makes sexual aversion so distressing is that, unlike other phobias (e.g., snakes, heights), it is possible to avoid the phobic stimulus with little interference in the individual's life. However, with sexual phobias, Kaplan noted that "its avoidance can be profoundly destructive" given that sexuality is a core feature of human existence.

Aversion itself is not actually defined in the DSM-IV (or DSM-III-R). In other contexts, it is conceptualized as an emotion (e.g., feelings of repugnance or extreme dislike) (Toronchuk & Ellis, 2007). Other aversions (e.g., conditioned taste aversion) may emphasize the behavioral correlates of aversion and not the emotional aspects. However, given that the DSM criteria indicate that there is aversion *and avoidance*, this implies that the definition of aversion focuses on the affective aspects and not on the behavioral aspects (as the latter is captured by "and avoidance").

It is likely (although this cannot be verified due to the unavailability of *DSM-III-R Sourcebooks*) that the empirical justification for including SAD as a new disorder in DSM-III-R stemmed from Kaplan's own patients and observations. Kaplan (1987) reported on the characteristics of 373 patients with sexual avoidance who were seen at the Human Sexuality Program of the Payne Whitney Clinic as well as a private clinic between 1976 and 1986. Kaplan found that 9% of those who avoided sex also met criteria for Panic Disorder and, as such, suggested that pharmacotherapy for the Panic Disorder would improve the sexual aversion. The proportion of those with Panic Disorder was even higher (25%) among those individuals who avoided sex and also had a phobia of sex. Another 25% of those with phobic avoidance of sex experienced emotional signs and symptoms of Panic Disorder but did not meet full criteria.

It is noteworthy that Kaplan (1987) originally described SAD as a sexual phobia. A considerable portion of Kaplan's book was spent on describing the panic experienced by these individuals and describing therapeutic approaches to phobias (in general) as well as Panic Disorder. Kaplan (1988) noted that individuals with Panic Disorder were particularly prone to SAD because of their personality traits of separation anxiety, rejection sensitivity, and overreaction to criticism from significant others such as lovers. The placement of SAD as a Sexual Dysfunction as opposed to a Specific Phobia at the time seems to have been related to the type of stimulus responsible for the phobic reaction (i.e., a sexual stimulus). However, the other Specific Phobias (then classed as Simple Phobias) were not similarly categorized according to the type of stimulus that provoked symptoms (e.g., public speaking phobia is not characterized as an Interpersonal Disorder, and fear of heights is not placed in a different category of related syndromes). Kaplan (1987) presented the DSM-III criteria for Simple Phobia (300.29) and pointed out the similarity to the proposed DSM-III-R criteria for SAD, stating: "It is not clear to me whether sexual phobia and aversion are two discrete disorders…or whether aversion is simply a form of sexual panic with especially intense autonomic reactions. At this time, I tend to conceptualize sexual aversion and phobic avoidance of sex as two clinical variations of sexual panic states" (p. 11). The DSM-IV-TR text on the Differential Diagnosis section of SAD indicates that "Although sexual aversion may technically meet criteria for Specific Phobia, this additional diagnosis is not given." The rationale for why this was the case was not provided and there was no information in the *DSM-IV Sourcebook* justifying this disclaimer. On the other hand, the Differential Diagnosis section of Specific Phobia makes no mention of SAD.

Despite the apparent similarities between sexual aversion and Specific Phobia, Janata and Kingsberg (2005) noted that a critical difference between the two was that the former was characterized by abhorrence and disgust while the latter was not. To explore the potential similarities between SAD, HSDD, and

worry (the latter was assessed because it is associated with many DSM-IV-TR disorders including anxiety disorders), 138 college students completed questionnaires such as the Sexual Aversion Scale (Katz, Gipson, Kearl, & Kriskovich, 1989), the Hurlbert Index of Sexual Desire (Apt & Hurlbert, 1992), and the Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990). Worry was only weakly associated with both sexual aversion and sexual desire scores, leading Janata and Kingsberg to conclude that worry was not a central feature of the sexual desire disorders.

In the DSM-IV-TR, SAD is diagnosed as lifelong or acquired. Crenshaw (1985) noted that occasionally sexual aversion is specific to a certain relationship and that outside of that relationship the person is able to function normally sexually. This would be deemed a situational SAD. Janata and Kingsberg (2005) prefer the categories of primary and secondary to refer to the acquisition of fear and anxiety before or after, respectively, the development of a healthy sexual relationship. A lifelong SAD is senseless for the individual who, perhaps, had their sexual debut in their teens, 20s, or even later. Secondly, because of the leading theory of SAD as being a conditioned and, therefore, acquired response, this also implies that it could never have been lifelong for conditioning would have had to take place at some point in time.

Interestingly, there was no change to the essential criterion for SAD (extreme aversion to and avoidance of sexual contact) from DSM-III-R to DSM-IV. It is also interesting to note that in the *DSM-IV Sourcebook* (Schiavi, 1996), there was reference to only two published empirical papers on SAD and both were published prior to DSM-III-R (American Psychiatric Association, 1987). One study compared 20 sexually aversive individuals with 35 controls. The *DSM-IV Sourcebook* noted that no reliability information were provided, but that those with SAD scored significantly higher on the State-Trait Anxiety Inventory (Spielberger, Gorusch, & Lushene, 1970). The only conclusion drawn by the Sexual Dysfunctions Work Group was that there was no evidence to support "narrowing the diagnosis of sexual aversion disorder to include individuals with aversions limited to one or a few components of the sexual interaction" (Schiavi, 1996, p. 1100). However, there was also no mention of justification for why SAD should continue to remain a diagnosable sexual dysfunction.

Prevalence

The precise prevalence of SAD is unknown and difficult to establish given that individuals avoid sexual encounters and therefore seldom present to sex therapy clinics. Based on clinical experience, Crenshaw (1985) believed that sexual aversion syndrome was the most common sexual dysfunction; however, Crenshaw noted that most clinicians "miss" the diagnosis because they are inexperienced in identifying it. In one of the few empirical studies of SAD, 382 college undergraduates completed a survey assessing the DSM-III-R diagnostic criteria for SAD (Katz et al., 1989). The 30-item Sexual Aversion Scale (SAS) assessed fears about AIDS, social evaluation, pregnancy, and sexual trauma. Katz et al. found high internal, test-retest, and item-total reliability of the scale. Katz et al. estimated the prevalence of sexual aversion severe enough to warrant treatment seeking to be approximately 10%, although 29% reported avoidance of nearly all genital contact. Among those with sexual aversion, there were significant fears about AIDS, and Katz et al. predicted that such a questionnaire would be important if AIDS were to spread to the heterosexual population. In a subsequent validation study of the SAS (Katz, Gipson, & Turner, 1992), scores on this measure were significantly correlated with scores on the Fear Survey Schedule (Wolpe & Lang, 2007), and individuals with a history of sexual abuse had higher scores of aversion. Since the articles by Katz et al. 20 years ago, I could not locate any additional published studies using the SAS.

Despite the large number of recent population-based epidemiological studies on sexual symptoms and distress, none have asked about the prevalence and associated features of sexual aversion. One exception is the large epidemiological Zurich Cohort Study, of which a subset of the questions focused on sexual symptoms in 363 participants. A total of 12 (3.3%) individuals reported feeling "constantly or once in a while extreme aversion to genital sexual contact" which caused "distinct suffering or relationship conflicts" (J. Angst, personal communication, February 23, 2009). Because of the small sample size, analyses of the associated correlates of sexual aversion were not possible.

Knowledge about gender differences in sexual aversion is virtually non-existent. However, Kingsberg and Janata (2003) noted that SAD primarily affects women and that men with SAD are more likely to avoid relationships and, therefore, distress due to sexual contact is less frequent than it is for women. In the college student sample studied by Katz et al. (1989), scores on the SAS were significantly higher for women than they were for men. Women also worried significantly more about being evaluated sexually by partners, were more avoidant, and were more fearful of intercourse than men.

Causal Mechanisms

Janata and Kingsberg (2005) asserted that SAD is likely best conceptualized as a conditioned aversion according to Mowrer's (1947) two-factor theory. It is possible that sexual stimuli were paired with painful or traumatic sexual stimuli, producing the aversive conditioned response. There is clinical (Janata & Kingsberg, 2005) and limited empirical (Noll, Trickett, & Putnam, 2003) support for a role for child sexual abuse in the

etiology of SAD. There are no empirical data supporting the speculation that SAD is due to a partner forcing sex upon an individual, despite what is claimed in some pop culture sources (www.marriagebuilders.com). Avoidance behavior then reinforces the conditioned avoidance. Because systematic desensitization has been found effective in two published case studies of women with SAD (Finch, 2001; Kingsberg & Janata, 2003), SAD was speculated to be similar to other anxiety disorders which respond quite well to systematic desensitization (Choy, Fyer, & Lipsitz, 2007). For women, it has been noted that, in general, SAD is less responsive to behavioral treatment than is HSDD (Schover & LoPiccolo, 1982); however, there are no published studies comparing behavior therapy in HSDD versus SAD. There have been no published longitudinal studies exploring the etiology of SAD so statements about proposed mechanisms are based on assertion only. Moreover, there are no published efficacy studies or case reports on treatment of SAD in men.

Kaplan (1987) also believed that Mowrer's (1947) two-factor theory explained the etiology of sexual aversion but added that reinforcement processes were responsible for its maintenance. Specifically, Kaplan argued that the sexual aversion was maintained because of a vicious cycle of avoidance and reinforcement of the avoidance behavior. Because avoidance allows the individual to be free of the significant sexual anxiety and distress, avoidance becomes self-perpetuating and therefore reinforcing.

Kaplan (1987) noted that psychoanalytic theories also attempt to explain the etiology of SAD in that the phobic anxiety is activated among those individuals with unresolved oedipal conflicts. For those 4–5 year old boys who do not mature from the stage of having sexual feelings for their mothers and being fearful of castration by their fathers, neurotic anxiety (and sexual aversion) may develop. Treatment is therefore aimed at resolving the oedipal complex. Unfortunately, this particular theory has never been tested directly nor have there been empirical tests of the efficacy of psychoanalysis for SAD.

Is Sexual Aversion Disorder a Sexual Desire Disorder?

Although SAD is listed as one of the two Sexual Desire Disorders, there appear to be few similarities between HSDD and SAD—the former being characterized by the absence of desire and the latter as the presence of fear and avoidance. Although Schover and LoPiccolo (1982) conceptualized SAD and HSDD as being at opposite ends of the same spectrum, Kaplan (1987) disagreed with this conceptualization, noting that individuals with SAD can continue to experience normal sexual desire, fantasize, and often masturbate to orgasm. Indeed, internet advice columns (e.g., psychcentral.com/ask-the-therapist) present queries from individuals with SAD symptoms despite apparent normal levels of sexual desire:

> I'm a 24 year old female, and I believe I suffer from sexual aversion disorder. I find the thought of all genital contact quite repulsive, and on occasions in the past when guys have tried to touch me below the waist I have become very panicky and upset. It's not that I have no sexual desire, I do, and I masturbate to orgasm around once a week.

In a sample of 376 patients who avoided sex, Kaplan (1987) found that 21% also met criteria for Inhibited Sexual Desire Disorder (now classified as HSDD). In an empirical test of the association between SAD and HSDD, although sexual desire and sexual aversion scores were significantly correlated ($r = .33$, $p < .001$), sexual aversion scores accounted for only 11% of the variance in sexual desire scores (Katz & Jardine, 1999). Research on the distinction between desire and aversion is extremely limited to outdated studies with poor methodological design. However, among those seeking treatment for sexual concerns, anxiety was significantly higher among those with sexual aversion compared to those with low sexual desire (Murphy & Sullivan, 1981). There was no information in the *DSM-IV Sourcebook* (Schiavi, 1996) justifying SAD as a Sexual Desire Disorder.

Overlap Between Sexual Aversion Disorder and Vaginismus

As reviewed by Binik (2009), there is some overlap between SAD and vaginismus, the latter of which is defined in DSM-IV by a recurrent or persistent involuntary vaginal muscle spasm. The International Consultation Committee sponsored by the American Urological Association Foundation refined the definition of vaginismus in recognition of the finding that vaginal muscle spasm was not universally present among women with vaginismus whereas fear of penetration was. This group described vaginismus as "The persistent or recurrent difficulties of the woman to allow vaginal entry of a penis, a finger, and/or any object, despite the woman's expressed wish to do so. There is often (phobic) avoidance and anticipation/fear of pain" (Basson et al., 2003). Basson et al. highlighted the phobic qualities of vaginismus and concluded that it was fear of penetration that characterized vaginismus more than vaginal spasm. Because women with vaginismus are fearful of (painful) vaginal penetration, this often results in avoidance behavior and even in aversion in severe cases. It is possible, therefore, that some cases of aversion are due to vaginismus, although both disorders can be diagnosed simultaneously. Although there are no empirical data that have sought to differentiate these two disorders, vaginismus is classified as a sexual pain disorder because of the overlap with dyspareunia. If the aversion is exclusively due to fear of pain, then the diagnosis indeed would be one of vaginismus and not SAD. Thus, there appears to be enough of a difference in the diagnostic descriptions of the two disorders to justify their assignment to different classes of sexual dysfunction.

Overlap Between Sexual Aversion Disorder and Specific Phobia

The DSM-IV-TR (American Psychiatric Association, 2000) criteria for Specific Phobia are listed in Table 2. If one were to consider these criteria in the context of the feared sexual stimulus, it is readily apparent that the individual with SAD could meet criteria for a Specific Phobia. Although the text on SAD indicates that "…sexual aversion may technically meet the criteria for Specific Phobia, this additional diagnosis is not given" (American Psychiatric Association, 1994, p. 499), paradoxically the text on Specific Phobia makes no mention of SAD. It might be inferred from these criteria that the Anxiety Disorders Work Group had not considered the fact that SAD could technically overlap with the criteria for Specific Phobia and therefore did not list it as a Differential Diagnosis. The rationale for why SAD *should* be classified as a Sexual Dysfunction and not an Anxiety Disorder is similarly not clarified. The limited empirical data available suggest that SAD is similar to Specific Phobias in that (1) it likely follows Mowrer's (1947) two-factor theory of pathogenesis and (2) it responds optimally to behavior therapy in the form of systematic desensitization.

Table 2 DSM-IV-TR diagnostic criteria for Specific Phobia (300.29)

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood)
B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. *Note*: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging
C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent
D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress
E. The avoidance, anxious-anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia
F. In individuals under age 18 years, the duration is less than 6 months
G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive–Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder
Specify type
Animal type
Natural environment type (e.g., heights, storms, water)
Blood–Injection–Injury type
Situational type (e.g., airplanes, elevators, enclosed spaces)
Other type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

Recommendations

It is perhaps no coincidence that Sexual Aversion Disorder was added to the DSM-III-R (American Psychiatric Association, 1987) under the influence of Kaplan in the same year that *Sexual Aversion, Sexual Phobias, and Panic Disorder* (Kaplan, 1987) was published. Kaplan was a major proponent for including SAD into the DSM based on clinical observations. However, its inclusion into the diagnostic taxonomy has not translated into increased research on the topic (as it perhaps was originally hoped). Instead, there are only a few case studies published on SAD and, since the publication of DSM-IV-TR in 2000, there have been no published epidemiological studies on the topic.

There are three possible alternatives for dealing with SAD in DSM-V. The APA draft guidelines for making changes to DSM-V (DSM-V Task Force Document, 2009) provides a list of five principles to consider when proposing a change to the DSM. These include: (1) to distinguish between psychiatric syndromes for purposes of guiding the most effective treatment and management; (2) to reduce confusion of syndromes with each other; (3) to take into account co-morbid symptoms which affect the outcome of treatment in the most effective manner; (4) to facilitate ease of use and promote clinical utility; and (5) to demonstrate validity on as many levels as possible. Among the principles that are most relevant to SAD is one that states that the goal is to distinguish among psychiatric syndromes for purposes of treatment. Changes should also reduce confusion among syndromes. Both of these points are relevant to the diagnostic category of SAD given its apparent overlap with phobias and possibly with vaginismus. Thus:

Option 1 is to remove SAD from the DSM-V and expand the definition of vaginismus to encompass women with sexual aversion. As noted earlier in this review, some women with vaginismus experience aversion to sexual activity. Crenshaw (1988) noted that there is a high correlation between primary sexual aversion and vaginismus in women, but this claim has never been empirically verified. The potential benefit of subsuming sexual aversion under the category of vaginismus is that women with vaginismus would not be further pathologized by having an additional disorder if they were aversive of sex. However, in women with SAD, the aversive stimulus is typically genital sexual contact with a partner, not necessarily fear/anticipation of pain, as in the case of vaginismus. Moreover, many (if not most) women with vaginismus also experience comorbid sexual pain, and this is not a clinical feature of women with SAD. One might speculate that the aversion to sex among women with vaginismus is, therefore, adaptive since

they are avoiding painful sexual activity. This appears not to be the case with SAD. Thus, although some women with vaginismus do experience aversive or phobic-like reactions to vaginal penetration, this is not the same group of women originally conceptualized by Kaplan (1987) as being sexually aversive. I am not in favor of subsuming sexual aversion under the category of vaginismus.

Option 2 is to remove SAD from the DSM-V and make the recommendation that cases of genital contact phobia be captured under the diagnosis of Specific Phobia. This would involve adding to the text description of Specific Phobia that aversion to sexual contact is one manifestation of phobia in the "Other Type" category. It would not be necessary to change the diagnostic criteria for Specific Phobia itself to account for sexual aversion given that, as outlined earlier, if one were to substitute "sexual stimulus" for "specific object" or "stimulus" in the criteria, this description captures the entity of SAD already. It is unclear why the DSM-IV-TR text description of SAD indicates that a diagnosis of Specific Phobia should not be given if one has SAD, particularly as a parallel statement is not made in the text description of Specific Phobia. Option 2 is in line with the Draft Criteria for proposing change to DSM in that it circumvents the problem of making a false distinction between Specific Phobia and SAD and therefore reduces confusion. A potential disadvantage of including phobia of sexual contact as a Specific Phobia is that patients might seek treatment for this problem in Anxiety Disorder clinics and not by sex therapy experts, thus shifting the focus of the problem away from the sexual/interpersonal aspects and focusing more on the anxiety-related aspects. This is a downside only on face-value given that the most efficacious treatment approaches for SAD have involved techniques borne out of the anxiety disorders literature (e.g., systematic desensitization). Just as the clinician treating public speaking phobias is not an expert in communication, it is not necessary for the clinician treating sexual phobia to be a sex therapist.

Option 3 is to retain SAD in the DSM-V as a Sexual Dysfunction. Given that there have not been any empirical publications to suggest improving the criteria, no recommendations can be made for doing so. However, the lack of research in this area, the absence of epidemiological and pathophysiological research, and the apparent overlap with Specific Phobia make this option the least desirable. Moreover, the current classification implies a false distinction between these two disorders and maintains confusion among clinicians about whether a sexual or an anxiety disorder is most appropriate. If the criteria set out in the Draft Guidelines for making changes to DSM-V had been used when SAD was considered for *inclusion* into DSM-III-R, it would not have passed the test. Reliability and validity data on the diagnostic criteria were not available, diagnostic validity of the syndrome was unknown, there were insufficient data published on a range of topics related to SAD, and epidemiological and services data, course, and treatment outcome data were nonexistent. Moreover, the requirement that the disorder in question is sufficiently distinct from other disorders to warrant designation as a separate disorder was not met and it could have been captured as a subtype of another disorder (Specific Phobia). It is possible that the historical influence of Kaplan overshadowed the lack of empirical data justifying SAD as a new diagnostic entity. With DSM-V and the emphasis placed on any changes being based on empirical science, SAD clearly would not have made its way into the DSM.

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