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

Genito-Pelvic Pain/Penetration Disorder

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

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

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

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

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

Specify whether:

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

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

Specify current severity:

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

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

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

Diagnostic Features

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

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

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

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

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

Associated Features Supporting Diagnosis

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

In addition to the subtype "lifelong/acquired," five factors should be considered during assessment and diagnosis of genito-pelvic pain/penetration disorder because they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's health status); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement); 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different women with this disorder.

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

Prevalence

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

Development and Course

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

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

Risk and Prognostic Factors

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

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

Culture-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

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

Functional Consequences of Genito-Pelvic Pain/Penetration Disorder

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

Differential Diagnosis

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

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

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

Comorbidity

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

Male Hypoactive Sexual Desire Disorder

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

A. Persistently or recurrently deficient (or absent) sexual/erotic thoughts or fantasies and desire for sexual activity. The judgment of deficiency is made by the clinician, taking into account factors that affect sexual functioning, such as age and general and sociocultural contexts of the individual's life.
B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
C. The symptoms in Criterion A cause clinically significant distress in the individual.
D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to thes effects of a substance/medication or another medical condition.

Specify whether:

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

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

Specify whether:

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

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

Specify current severity:

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

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

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

Diagnostic Features

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

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

Associated Features Supporting Diagnosis

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

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of male hypoactive sexual desire disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's health status); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement); 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treat-

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

Prevalence

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

Development and Course

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

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

Risk and Prognostic Factors

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

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

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

Culture-Related Diagnostic Issues

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

Gender-Related Diagnostic Issues

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