

Female Sexual Interest/Arousal Disorder

Code: 302.72 (F52.22)

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Diagnostic Criteria 302.72 (F52.22)
A. Lack of, or significantly reduced, sexual interest/arousal, as manifested by at least three of the following:
1. Absent/reduced interest in sexual activity.
2. Absent/reduced sexual/erotic thoughts or fantasies.
3. No/reduced initiation of sexual activity, and typically unresponsive to a partner's attempts to initiate.
4. Absent/reduced sexual excitement/pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
5. Absent/reduced sexual interest/arousal in response to any internal or external sexual/erotic cues (e.g., written, verbal, visual).
6. Absent/reduced genital or nongenital sensations during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (in identified situational contexts or, if generalized, in all contexts).
B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
C. The symptoms in Criterion A cause clinically significant distress in the individual.
D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.
Specify whether:
Lifetime: The disturbance has been present since the individual became sexually active.
Acquired: The disturbance began after a period of relatively normal sexual function.
Specify whether:
Generalized: Not limited to certain types of stimulation, situations, or partners.
Situational: Only occurs with certain types of stimulation, situations, or partners.
Specify current severity:
Mild: Evidence of mild distress over the symptoms in Criterion A.
Moderate: Evidence of moderate distress over the symptoms in Criterion A.
Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features
In assessing female sexual interest/arousal disorder, interpersonal context must be taken into account. A "desire discrepancy," in which a woman has lower desire for sexual activity than her partner, is not sufficient to diagnose female sexual interest/arousal disorder. In order for the criteria for the disorder to be met, there must be absence or reduced frequency or intensity of at least three of six indicators (Criterion A) for a minimum duration of approximately 6 months (Criterion B). There may be different symptom profiles across women, as well as variability in how low sexual interest and arousal are expressed. For example, in one woman, sexual interest/arousal disorder may be expressed as a lack of interest in sexual activity, an absence of erotic or sexual thoughts, and reluctance to initiate sexual activity and respond to a partner's sexual invitations. In another woman, an inability to become sexually excited, to respond to sexual stimuli with sexual desire, and a corresponding lack of signs of physical sexual arousal may be the primary features. Because sexual desire and arousal frequently coexist and are elicited in response to adequate sexual cues, the criteria for female sexual interest/arousal disorder take into account that difficulties in desire and arousal often simultaneously characterize the complaints of women with this disorder. Short-term changes in sexual interest or arousal are common and may be adaptive responses to events in a woman's life and do not represent a sexual dysfunction. Diagnosis of female sexual interest/arousal disorder requires a minimum duration of symptoms of approximately 6 months as a reflection that the symptoms must be a persistent problem. The estimation of persistence may be determined by clinical judgment when a duration of 6 months cannot be ascertained precisely.

There may be absent or reduced frequency or intensity of interest in sexual activity (Criterion A1), which was previously termed hypoactive sexual desire disorder. The frequency or intensity of sexual and erotic thoughts or fantasies may be absent or reduced (Criterion A2). The expression of fantasies varies widely across women and may include memories of past sexual experiences. The normative decline in sexual thoughts with age should be taken into account when this criterion is being assessed. Absence or reduced frequency of initiating sexual activity and of reactivity to a partner's sexual invitations (Criterion A3) is a behaviorally focused criterion. A couple's beliefs and preferences for sexual initiation patterns are highly relevant to the assessment of this criterion. There may be absent or reduced sexual excitement or pleasure during sexual activity in almost all or all (approximately 75%–100%) sexual encounters (Criterion A4). Lack of pleasure is a common presenting clinical complaint in women with low desire. Among women who report low sexual desire, there are fewer sexual or erotic cues that elicit sexual interest or arousal (i.e., there is a lack of "responsive desire"). Assessment of the adequacy of sexual stimuli will assist in determining if there is a difficulty with responsive sexual desire (Criterion A5). Frequency or intensity of genital or nongenital sensations during sexual activity may be reduced or absent (Criterion A6). This may include reduced vaginal lubrication/vasocongestion, but because physiological measures of genital sexual response do not differentiate women who report sexual arousal concerns from those who do not, the self-report of reduced or absent genital or nongenital sensations is sufficient.

For a diagnosis of female sexual interest/arousal disorder to be made, clinically significant distress must accompany the symptoms in Criterion A. Distress may be experienced as a result of the lack of sexual interest/arousal or as a result of significant interference in a woman's life and well-being. If a lifelong lack of sexual desire is better explained by one's self-identification as "asexual," then a diagnosis of female sexual interest/arousal disorder would not be made.

Associated Features Supporting Diagnosis

Female sexual interest/arousal disorder is frequently associated with problems in experiencing orgasm, pain experienced during sexual activity, infrequent sexual activity, and couple-level discrepancies in desire. Relationship difficulties and mood disorders are also frequently associated features of female sexual interest/arousal disorder. Unrealistic expectations and norms regarding the "appropriate" level of sexual interest or arousal, along with poor sexual techniques and lack of information about sexuality, may also be evident in women diagnosed with female sexual interest/arousal disorder. The latter, as well as normative beliefs about gender roles, are important factors to consider.

In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of female sexual interest/arousal disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's health status); 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., prohibitions related to prohibitions against sexual activity, attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Note that each of these factors may contribute differently to the presenting symptoms of different women with this disorder.

Prevalence

The prevalence of female sexual interest/arousal disorder, as defined in this manual, is unknown. The prevalence of low sexual desire and of problems with sexual arousal (with and without associated distress), as defined by DSM-IV or ICD-10, may vary markedly in relation to age, cultural setting, duration of symptoms, and presence of distress. Regarding duration of symptoms, there are striking differences in prevalence estimates between short-term and persistent problems related to lack of sexual interest. When distress about sexual functioning is required, prevalence estimates are markedly lower. Some older women report less distress about low sexual desire than younger women, although sexual desire may decrease with age.

Development and Course

By definition, lifelong female sexual interest/arousal disorder suggests that the lack of sexual interest or arousal has been present for the woman's entire sexual life. For Criteria A3, A4, and A6, which assess functioning during sexual activity, a subtype of lifelong would mean presence of symptoms since the individual's first sexual experiences. The acquired subtype would be assigned if the difficulties with sexual interest or arousal developed after a period of nonproblematic sexual functioning. Adaptive and normative changes in sexual functioning may result from partner-related, interpersonal, or personal events and may be transient in nature. However, persistence of symptoms for approximately 6 months or more would constitute a sexual dysfunction.

There are normative changes in sexual interest and arousal across the life span. Furthermore, women in relationships of longer duration are more likely to report engaging in sex despite no obvious feelings of sexual desire at the outset of a sexual encounter compared with women in shorter-duration relationships. Vaginal dryness in older women is related to age and menopausal status.

Risk and Prognostic Factors

Temperamental: Temperamental factors include negative cognitions and attitudes about sexuality and past history of mental disorders. Differences in propensity for sexual excitation and sexual inhibition may also predict the likelihood of developing sexual problems. Environmental: Environmental factors include relationship difficulties, partner sexual functioning, and developmental history, such as early relationships with caregivers and childhood stressors. Genetic and physiological: Some medical conditions (e.g., diabetes mellitus, thyroid dysfunction) can be risk factors for female sexual interest/arousal disorder. There appears to be a strong influence of genetic factors on vulnerability to sexual problems in women. Psychophysiological research using vaginal photoplethysmography has not found differences between women with and without perceived lack of genital arousal.

Culture-Related Diagnostic Issues

There is marked variability in prevalence rates of low desire across cultures. Lower rates of sexual desire may be more common among East Asian women compared with Euro-Canadian women. Although the lower levels of sexual desire and arousal found in men and women from East Asian countries compared with Euro-American groups may reflect less interest in sex in those cultures, the possibility remains that such group differences are an artifact of the measures used to quantify desire. A judgment about whether low sexual desire constitutes a disorder must take into account the fact that different cultures may pathologize some behaviors and not others.

Gender-Related Diagnostic Issues

By definition, the diagnosis of female sexual interest/arousal disorder is only given to women. Discussing difficulties with sexual desire in men would be considered under male hypoactive sexual desire disorder.

Functional Consequences of Female Sexual Interest/Arousal Disorder

Difficulties in sexual interest/arousal are often associated with decreased relationship satisfaction.

Differential Diagnosis

Nonsexual mental disorders: Nonsexual mental disorders, such as major depressive disorder, in which there is "markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day," may explain the lack of sexual interest/arousal. If the lack of interest or arousal is completely attributable to another mental disorder, then a diagnosis of female sexual interest/arousal disorder would not be made.

Substance/medication use: Substance or medication use may explain the lack of interest/arousal. Another medical condition: If the sexual symptoms are considered to be almost exclusively associated with the effects of another medical condition (e.g., diabetes mellitus, endothelial disease, thyroid dysfunction, central nervous system disease), then a diagnosis of female sexual interest/arousal disorder would not be made.

Interpersonal factors: If interpersonal or significant contextual factors, such as severe relationship distress, intimate partner violence, or other significant stressors, explain the sexual interest/arousal symptoms, then a diagnosis of female sexual interest/arousal disorder would not be made.

Other sexual dysfunctions: The presence of another sexual dysfunction does not rule out a diagnosis of female sexual interest/arousal disorder. It is common for women to experience more than one sexual dysfunction. For example, the presence of chronic genital pain may lead to a lack of desire for the (painful) sexual activity. Lack of interest and arousal during sexual activity may impair orgasmic ability. For some women, all aspects of the sexual response may be unsatisfying and distressing. Inadequate or absent sexual stimuli: When differential diagnoses are being considered, it is important to assess the adequacy of sexual stimuli within the woman's sexual experience. In cases where inadequate or absent sexual stimuli are contributing to the clinical picture, there may be evidence for clinical care, but a sexual dysfunction diagnosis would not be made. Similarly, transient and adaptive alterations in sexual functioning that are secondary to a significant life or personal event must be considered in the differential diagnosis.