differentiating between a delayed ejaculation that is fully explained by another medical condition or injury (or its treatment) and a delayed ejaculation attributable to a variety of proportionally different biomedical-psychosocial and cultural factors that determine the symptom(s). A number of medical conditions or injuries, along with their treatments, may produce delays in ejaculation independent of psychosocial and cultural issues.

Delayed ejaculation must be differentiated from a number of urological conditions (especially other ejaculatory disorders), including retrograde ejaculation or *anejaculation*, which is typically the result of etiologies ranging from hormonal to neurological and/or anatomical abnormalities, including ejaculatory duct obstruction and other urological disorders.

Substance/medication use. A number of pharmacological agents, such as antidepressants, antipsychotics, α sympathetic drugs, alcohol, and opioid drugs, can cause ejaculatory problems. In such cases, the diagnosis is substance/medication-induced sexual dysfunction instead of delayed ejaculation.

Dysfunction with orgasm. It is important in the history to ascertain whether the complaint concerns delayed ejaculation or the sensation of orgasm, or both. Ejaculation occurs in the genitals, whereas the experience of orgasm is believed to be primarily subjective. Ejaculation and orgasm usually occur together but not always. For example, a male with a normal ejaculatory pattern may complain of decreased pleasure (i.e., anhedonic ejaculation). Such a complaint would not be coded as delayed ejaculation but could be coded as other specified sexual dysfunction or unspecified sexual dysfunction.

Comorbidity

There is some evidence to suggest that delayed ejaculation may be more common in severe forms of major depressive disorder.

Erectile Disorder

Diagnostic Criteria F52.21

A. At least one of the three following symptoms must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
   1. Marked difficulty in obtaining an erection during sexual activity.
   2. Marked difficulty in maintaining an erection until the completion of sexual activity.
   3. Marked decrease in erectile rigidity.

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 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 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

The essential feature of erectile disorder is a marked difficulty in obtaining or maintaining an erection or a marked decrease in erectile rigidity in all or almost all occasions of sexual activity (Criterion A) that has persisted for at least 6 months (Criterion B) and that causes clinically significant distress in the individual (Criterion C). A careful sexual history is necessary to ascertain that the problem has been present for a significant duration of time (i.e., at least approximately 6 months) and occurs on the majority of sexual occasions (i.e., at least 75% of the time). Symptoms may occur only in specific situations involving certain types of stimulation or partners, or they may occur in a generalized manner in all types of situations, stimulation, or partners.

This chapter uses the terms *erectile disorder* and *erectile dysfunction*, which are not synonymous. *Erectile dysfunction* is a widely used descriptive term (including in ICD-10) that refers to difficulty getting and maintaining an erection. *Erectile disorder* is the more specific DSM-5 diagnostic category in which erectile dysfunction persists for at least 6 months and causes distress in the individual.

Associated Features

Many males with erectile disorder may have low self-esteem, low self-confidence, and a decreased sense of masculinity, and may experience depressed mood. Erectile dysfunction is also strongly associated with feelings of guilt, self-blame, sense of failure, anger, and concern about disappointing one's partner. Fear and/or avoidance of future sexual encounters may occur. Decreased sexual satisfaction and reduced sexual desire in the individual's partner are common.

In addition to considerations of applicable subtypes (i.e., whether the erectile dysfunction has

been present since the individual became sexually active or began after a period of relatively normal sexual function, and whether the erectile dysfunction is generalized or occurs only with certain types of stimulation, situations, or partners), the following factors are important to consider in the assessment of erectile disorder: 1) partner factors (e.g., partner's sexual problems or health); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., hypoactive sexual desire), psychiatric comorbidity (e.g., depression, anxiety), or stressors such as job loss or stress; 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); 5) medical factors, particularly surgery (e.g., transurethral resection of the prostate), hypogonadism, or neurological conditions

(e.g., multiple sclerosis, diabetic neuropathy); and 6) use of substances or medications that might inhibit ejaculation (e.g., use of serotonergic drugs).

Prevalence

The prevalence of lifelong versus acquired erectile disorder is unknown. There is a strong age-related increase in both prevalence and incidence of problems with erection, particularly after age 50 years. Internationally, the prevalence of erectile disorder in the general population is approximately 13%–21% of males ages 40–80 years. Rates appear to be lower than 10% in males younger than 40 years, about 20%–40% in males in their 60s, and 50%–75% in males older than 70 years. In a longitudinal study in Australia, 80% of males age 70 and older experienced erectile disorder. In a review of studies largely from Western countries, about 20% of males feared erectile problems on their first sexual experience, whereas approximately 8% experienced erectile problems that hindered penetration during their first sexual experience. Among U.S.-based respondents to an online survey, there was no statistically significant difference in the prevalence of erectile disorder by ethnoracial background. Nationally representative U.S. data show that the prevalence of erectile difficulties is similar in older males who have sex with males or with both males and females.

Development and Course

Erectile failure on first sexual attempt has been found to be related to having sex with a previously unknown partner, concomitant use of drugs or alcohol, not wanting to have sex, and peer pressure. There is minimal evidence regarding the persistence of such problems after the first attempt. It is assumed that most of these problems spontaneously remit without professional intervention, but some males may continue to have episodic problems. In contrast, acquired erectile disorder is often associated with biological factors such as diabetes and cardiovascular disease. Acquired erectile disorder is likely to be persistent in most men.

The natural history of lifelong erectile disorder is unknown. Clinical observation supports the association of lifelong erectile disorder with psychological factors that are self-limiting or responsive to psychological interventions, whereas, as noted above, acquired erectile disorder is more likely to be related to biological factors and to be persistent. The incidence of erectile disorder increases with age. A minority of males diagnosed as having moderate erectile failure

may experience spontaneous remission of symptoms without medical intervention. Distress associated with erectile disorder is lower in older males as compared with younger males.

Risk and Prognostic Factors

Course modifiers. Risk factors for acquired erectile dysfunction and, as a consequence, erectile disorder include age, smoking tobacco, lack of physical exercise, diabetes, and decreased desire.

Culture-Related Diagnostic Issues

Prevalence of erectile disorder varies across countries. It is unclear to what extent these variations represent differences in cultural expectations as opposed to genuine differences in the frequency of erectile failure. Differential endorsement may be related to cultural concerns about appearing weak or less masculine or to diverse cultural norms about changes in erectile function during healthy aging. Cultural expectations concerning marital relationships, sexual performance, fertility, and gender roles can influence anxieties that may contribute to erectile disorder. Based on responses to an online survey, erectile disorder may be associated with concern about genital size in the United States and the Middle East and with fears of male infertility more frequently in the Middle East.

Sex- and Gender-Related Diagnostic Issues

By definition, the diagnosis of erectile dysfunction is only given to males. Distressing difficulties with sexual arousal in women would be considered under female sexual interest/arousal disorder.

Diagnostic Markers

Nocturnal penile tumescence testing and measured erectile turgidity during sleep can be employed to help differentiate organic from psychogenic erectile problems on the assumption that adequate erections during rapid eye movement sleep indicate a psychological etiology to the problem. A number of other diagnostic procedures may be employed depending on the clinician's assessment of their relevance given the individual's age, comorbid medical problems, and clinical presentation. Doppler ultrasonography and intravascular injection of vasoactive drugs, as well as invasive diagnostic procedures such as dynamic infusion cavernosography, can be used to assess vascular integrity. Pudendal nerve conduction studies, including somatosensory evoked potentials, can be employed when a peripheral neuropathy is suspected. Testing for low levels of serum bioavailable or free testosterone is appropriate especially when diabetes is present, for men who also experience hypoactive desire, and for those who do not respond to phosphodiesterase type 5 inhibitors. Thyroid function may also be assessed. Determination of fasting serum glucose is useful to screen for the presence of diabetes mellitus. The assessment of serum lipids is important, as erectile disorder in males 40 years and older is predictive of the future risk for coronary artery disease.

Association With Suicidal Thoughts or Behavior

Among males receiving treatment for erectile disorder with comorbid depression, elevated rates

of suicidal thoughts or behavior have been observed; while the affected males attributed the suicidal symptoms to their erectile disorder, the presence of depression was also a likely contributing factor. Elevated suicide rates among males with prostate cancer may in part be related to treatment-associated erectile dysfunction and consequent depressive symptoms.

Functional Consequences of Erectile Disorder

Erectile disorder can interfere with fertility and produce both individual and interpersonal distress. Fear and/or avoidance of sexual encounters may interfere with the ability to develop intimate relationships. Significant psychological distress may occur among males presenting with erectile disorder.

Differential Diagnosis

Nonsexual mental disorders. Major depressive disorder and erectile disorder are closely associated, and erectile disorder accompanying severe depressive disorder may occur. If the erectile difficulties are better explained by another mental disorder, such as major depression, then a diagnosis of erectile disorder would not be made.

Normal erectile function. The differential should include consideration of normal erectile function in males with excessive expectations.

Substance/medication use. An onset of erectile dysfunction that coincides with the beginning of substance/medication use and that dissipates with discontinuation of the substance/medication or dose reduction is suggestive of a substance/medication-induced sexual dysfunction, which should be diagnosed instead of erectile disorder.

Another medical condition. The most difficult aspect of the differential diagnosis of erectile disorder is ruling out erectile problems that are fully explained by medical factors. Such cases would not receive a diagnosis of a mental disorder. The distinction between erectile disorder as a mental disorder and erectile dysfunction as the result of another medical condition is usually unclear, and many cases will have complex, interactive biological and psychiatric etiologies. If the individual is older than 40–50 years and/or has concomitant medical problems, the differential diagnosis should include medical etiologies, especially vascular disease. The presence of an organic disease known to cause erectile problems does not confirm a causal relationship. For example, a male with diabetes mellitus can develop erectile disorder in response to psychological stress. In general, erectile dysfunction due to organic factors is generalized and gradual in onset. An exception would be erectile problems after traumatic injury to the nervous innervation of the genital organs (e.g., spinal cord injury). Erectile problems that are situational and inconsistent and that have an acute onset after a stressful life event are most often attributable to psychological events. An age younger than 40 years is also suggestive of a psychological etiology to the difficulty.

Comorbidity

Erectile disorder can be comorbid with other sexual diagnoses, such as premature (early)

compared with women. However, preliminary data suggest that the overlap between sexual desire and sexual arousal (erectile function) is also very common in men, particularly when they present for help regarding sexual problems. Regarding sexual orientation, data suggest that low sexual desire is more commonly reported by gay men (19%) than by heterosexual men (9%).

Differential Diagnosis

Nonsexual mental disorders. Nonsexual mental disorders, such as major depressive disorder, which is characterized by "markedly diminished interest or pleasure in all, or almost all, activities," may explain the lack of sexual desire. If the lack of desire is better explained by another mental disorder, then a diagnosis of male hypoactive sexual desire disorder would not be made.

Substance/medication use. An onset of male hypoactive sexual desire that coincides with the beginning of substance/medication use and that dissipates with discontinuation of the substance/medication or dose reduction is suggestive of a substance/medication-induced sexual dysfunction, which should be diagnosed instead of male hypoactive sexual desire disorder.

Another medical condition. If the low/absent desire and deficient/absent erotic thoughts or fantasies are better explained by the effects of another medical condition (e.g., hypogonadism, diabetes mellitus, thyroid dysfunction, central nervous system disease), then a diagnosis of male hypoactive sexual desire disorder would not be made.

Interpersonal factors. If interpersonal or significant contextual factors, such as severe relationship distress or other significant stressors, are associated with the loss of desire in the man, then a diagnosis of male hypoactive sexual desire disorder would not be made.

Other sexual dysfunctions. The presence of another sexual dysfunction does not rule out a diagnosis of male hypoactive sexual desire disorder; there is some evidence that up to one-half of men with low sexual desire also have erectile difficulties, and slightly fewer may also have early ejaculation difficulties. If the man's low desire is explained by self-identification as an asexual, then a diagnosis of male hypoactive sexual desire disorder is not made.

Comorbidity

Male hypoactive sexual desire disorder is rarely the sole sexual diagnosis in men. Erectile dysfunction, delayed ejaculation, and premature (early) ejaculation are often comorbid diagnoses. Depression and other mental disorders, as well as endocrinological factors, are often comorbid with male hypoactive sexual desire disorder.

Premature (Early) Ejaculation

Diagnostic Criteria — F52.4

A. A persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it.

Note: Although the diagnosis of premature (early) ejaculation may be applied to individuals engaged in nonvaginal sexual activities, specific duration criteria have not been established for these activities.

B. The symptom in Criterion A must have been present for at least 6 months and must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts).

C. The symptom in Criterion A causes 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 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 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: Ejaculation occurring within approximately 30 seconds to 1 minute of vaginal penetration.

Moderate: Ejaculation occurring within approximately 15–30 seconds of vaginal penetration.

Severe: Ejaculation occurring prior to sexual activity, at the start of sexual activity, or within approximately 15 seconds of vaginal penetration.

Diagnostic Features

Premature (early) ejaculation is manifested by ejaculation that occurs prior to or shortly after vaginal penetration, operationalized by an individual's estimate of ejaculatory latency (i.e., elapsed time before ejaculation) after vaginal penetration. Although the diagnostic criteria specify penile-vaginal sex, it is reasonable to assume that similar estimates of ejaculatory latency apply to males having sex with males, as well as to other sexual behaviors. Estimated and measured intravaginal ejaculatory latencies are highly correlated as long as the ejaculatory latency is of short duration; therefore, self-reported estimates of ejaculatory latency are sufficient for diagnostic purposes. A 60-second intravaginal ejaculatory latency time was previously considered to be an appropriate cutoff for the diagnosis of lifelong premature (early) ejaculation in men; however, expert consensus now considers this latency time to be too brief and instead

recommends a 120-second threshold.

Associated Features

Many males with premature (early) ejaculation complain of a sense of lack of control over ejaculation and report apprehension about their anticipated inability to delay ejaculation on future sexual encounters.

The following factors may be relevant in the evaluation of any sexual dysfunction: 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., history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), and stressors (e.g., job loss, bereavement); 4) cultural/religious factors (e.g., lack of privacy, inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment.

Prevalence

Estimates of the prevalence of premature (early) ejaculation vary widely depending on the definition utilized. Internationally, a prevalence range of 8%–30% has been reported across all ages, with even lower and higher rates in other studies. Prevalence of premature (early) ejaculation may increase with age. For example, the prevalence among males ages 18–30 in Switzerland and Turkey is about 9%–11%, while the reported prevalence of concern among males ages 50–59 in the United States about how rapidly they ejaculate may be as high as 55%. When premature (early) ejaculation is defined as ejaculation occurring within approximately 1 minute of vaginal penetration, only 1%–3% of males would be diagnosed with the disorder.

Development and Course

By definition, lifelong premature (early) ejaculation starts during a male's initial sexual experiences and persists thereafter. Some males may experience premature (early) ejaculation during their initial sexual encounters but gain ejaculatory control over time. It is the persistence of ejaculatory problems for longer than 6 months that determines the diagnosis of premature (early) ejaculation. In contrast, some males develop the disorder after a period of having a normal ejaculatory latency, known as *acquired premature (early) ejaculation.* There is far less known about acquired premature (early) ejaculation than about lifelong premature (early) ejaculation. The acquired form likely has a later onset, usually appearing during or after the fourth decade of life. Lifelong is relatively stable throughout life.

Risk and Prognostic Factors

Temperamental. Premature (early) ejaculation may be more common in males with anxiety disorders, especially social anxiety disorder.

Genetic and physiological. There is a moderate genetic contribution to lifelong premature (early) ejaculation. Premature (early) ejaculation may be associated with dopamine transporter gene polymorphism or serotonin transporter gene polymorphism. Thyroid disease, prostatitis, and