VOLUME 7 ◆ NUMBER 6 ◆ 2010

THE JOURNAL OF Sexual Medicine

BASIC SCIENCE & CLINICAL RESEARCH IN MALE & FEMALE SEXUAL FUNCTION & DYSFUNCTION

BASIC SCIENCE & CLINICAL RESEARCH IN MALE & FEMALE SEXUAL FUNCTION & DYSFUNCTION • BASIC SCIENCE & CLINICAL RESEARCH IN MALE & FEMALE SEXUAL FUNCTION & DYSFUNCTION

Official Journal of
The International Society for Sexual Medicine

Africa Gulf Society for Sexual Medicine (AGSSM)
Asia Pacific Society for Sexual Medicine (APSSM)
European Society for Sexual Medicine (ESSM)
Latin American Society for Sexual Medicine (SLAMS)
Sexual Medicine Society of North America (SMSNA)
International Society for the Study of Women's Sexual Health (ISSWSH)

WILEY-BLACKWELL

http://www.jsm.issm.info

Responses to the Proposed DSM-V Changes

DOI: 10.1111/j.1743-6109.2010.01865.x

The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM)-V committee is charged with examining empirical evidence for either maintaining or changing the current diagnostic criteria for female sexual dysfunction (FSD). At the 10th annual meeting of the International Society for the Study of Women's Sexual Health (ISSWSH) held recently in St. Petersburg Florida, Dr. Taylor Segraves presented the update of the DSM-V committee's proposed changes in the diagnostic criteria from the DSM-IV-TR criteria for FSD.

Dr. Segraves explained that DSM diagnostic continuity should be maintained whenever possible; however, for any changes in diagnosis, the evidence required to promote that change should be proportional to the magnitude of the change itself as well as to the magnitude of the problems with existing criteria. His slides are available in the ISSWSH program book. During the presentation, Dr. Segraves repeatedly asked for feedback concerning the proposed diagnostic systems for FSD in DSM-V. He frequently stated that these proposed changes may or may not meet the needs of some of our patients with FSD and may or may not meet the needs of some of us as clinicians and researchers who practice and study women's sexual health.

The ISSWSH is unique in its international, multidisciplinary makeup as an organization dedicated to providing opportunities for communication among scholars, researchers, and practitioners about women's sexual health, to support the highest standards of ethics and professionalism in research, education and clinical practice of women's sexual health, and to provide the public with accurate information about women's sexual health. As evidence of the broad nature of the society, ISSWSH members of the board have been from diverse specialties including psychology, psychiatry, internal medicine, gynecology, urology, pharmacology, dermatology, basic science, physical therapy, allied heath care, and education. At the core of the success of ISSWSH is this diversity that provides critical varied and distinctive input into the field of women's sexual health, including the DSM-V proposed changes, despite the belief by some members of the DSM-V committee that the changes are not controversial.

In 1998, at the biennial meeting of the International Society for Sexual Medicine in Boston, Dr. William Masters, the invited grand master speaker, admitted publicly that his original theory concerning erectile dysfunction being 90% psychological, was, in fact, wrong. He stated almost 22 years ago, and more than 25 years after his research studies were performed, that erectile dysfunction was primarily a result of both biologic and psychological problems, with the psychological issues seemingly secondary to the primary biologic concerns. Today, we are still having the biology–psychology debate, but it has moved from men to women.

The Journal of Sexual Medicine (*JSM*), the official journal of ISSWSH, is multidisciplinary and geared toward both the biologic and psychological sexual medicine health care communities. The *JSM* was proud to be selected as the sexual medicine journal for publication of all the manuscripts with the proposed DSM-V changes regarding men's sexual dysfunctions [1–3]. Parallel manuscripts regarding women's sexual dysfunctions were published in *Archives of Sexual Behavior*, a primarily psychology-focused journal. Because of the choice of publication, members of ISSWSH who were not psychologists were not yet aware of these proposed changes. Dr. Segraves' presentation generated a great deal of discussion.

The Journal of Sexual Medicine appears to be the perfect vehicle to make available to the DSM-V committee selected comments. Experts from many aspects of women's sexual health were invited to provide commentary in a timely manner. Although many experts said they would provide this commentary, time constraints kept some from writing but it is expected they will follow up by other means.

The proposed changes are listed below so that the readers of the *JSM* have an opportunity to see them. After the changes are a series of invited commentaries reflecting different opinions, many based on available evidence, showing beyond a reasonable doubt that problems of FSD are not purely psychological and therefore need to be considered

of the impact that the conditions have on the possibilities of the individual to fulfill his/her sexual rights, and ultimately in his/her general well-being, and not in a popularity test of the construct to be considered. However, lack of evidence is not equivalent to nonexistence.

There are other problems with the suggested classification that could merit a comment much longer than this small commentary. The exclusion of the sexual aversion disorder deserves ambivalent reaction: it is clear that its inclusion on sexual desire disorders on DSM-IV was problematic; however, excluding it completely form the list of sexual problems can damage the patients who actually have the pathology: the fact that this is a form of an anxiety disorder: specific phobia would justify its inclusion in that category if most psychiatrist were prone to treat and identify sexual problems. However, there has been a continuous decline in the interest of psychiatrist on sexual medicine, a process that has occurred as therapeutic alternatives have appeared come from other medical specialties. Leaving sexual aversion out of the classification of sexual disorders will facilitate the misidentification of the problem by the proper professional.

In contrast, the modifications proposed for FOD seem to improve diagnostic accuracy, the problem here is that the FOD recognizes the importance of medical conditions, and the diagnosis 625.8 "Other Female Sexual Dysfunction Due to a General Medical Condition" would be very difficult to differentiate when, for instance, the FOD is due to diabetes mellitus and to decide which diagnosis to apply.

What we really need is a two-level classification, one classification organized at the syndromic level, where problems that appear in people's sexual lives are clearly delineated and described on the basis on their impact of wellbeing (to prevent unfair pathologization of conditions that really do nothing to people wellness), such classification is unlikely to be produced by a psychiatric association as such a classification (i.e., DSM-V) should limit itself to include psychiatric conditions. In addition, an etiological-based classification is very much needed and desirable: the diagnostic identification, treatment plan, and foreseeable outcome of a female with sexual difficulties needs an etiological classification to guide treatment, as the actions to be taken are very different depending on the specific etiological factor found in the clinical evaluation.

The task for these efforts should be placed in societies as the International Society for Sexual Medicine, or due to the impact on American health care system, on the Sexual Medicine Society of North America. I certainly hope that in the forthcoming future we can produce such much needed systems of classification of sexual problems.

Eusebio Rubio-Aurioles, MD, PhD
Asociación Mexicana para la Salud Sexual, A.C. (AMSSAC)
Mexico City, Mexico

The authors of this commentary, two gynecologists (AG, MK), a uro-gynecologist (LB), a gynecologic nurse practitioner/sexologist (SK), a psychologist (CP), and a woman's health physical therapist (PM), all specialize in the diagnosis and treatment of women with vulvar pain and pain during intercourse. We applaud the proposal of the DSM-V to recategorize penetrative pain difficulties (characteristic of the condition previously termed vaginismus) as genito-pelvic pain [67].

For generations, gynecologists and urologists (ourselves included) had minimal training in the evaluation and treatment of sexual dysfunction, including the sexual pain disorders. In addition, even the meager training we did receive emphasized (without supporting evidence) that women with sexual pain had been the victims of sexual abuse—whether they remembered it or not. These women, we were taught, had a subconscious fear of penetration; hence, vaginismus. This view allowed gynecologists and urologists to abdicate the treatment of sexual pain to mental health providers such as psychologists and sex therapists. Yet, these mental health professionals did not directly treat the pain component of sexual pain conditions either; most focused on psychosexual issues as the prevailing attitude was that it was the sexual—not the pain—component that required attention.

In the decade since the DSM-IV-R was published however, there has been great progress in understanding the sexual pain disorders. It is now recognized that the most common cause of sexual pain in premenopausal women is *not* vaginismus but is provoked vestibulodynia (PVD). Additionally, further research has established that vaginismus and dyspareunia overlap substantially and in fact, are difficult to separate [68]. Furthermore, researchers have used a combination of epidemiology, basic science, and clinical research to give us insight into the different causes of PVD [69–72]. In 1980, a twenty-year-old woman who presented to her gynecologist with insertional dyspareunia would have been told that she had vaginismus and

would have been referred to a sex therapist. However, in 2010, that same woman can be tested for a genetic polymorphism that predispose her to chronic inflammation [73], which has caused her to develop a proliferation of c-afferent nociceptors in her vestibular mucosa [74]. In addition, she can be offered treatments that target the underlying pathophysiology of her disease process [75,76] and be referred to other specialist who can address her sexual issues and pelvic floor dysfunction, for example.

Despite these advancements, sexual pain continues to be primarily a "sexual problem in DSM-IV TR terminology." We strongly believe that genito-pelvic pain should be classified with the pain disorders, not with the sexual dysfunctions. As clinicians who evaluate and treat thousands of women each year with vulvar pain and dyspareunia, we clearly understand that "the pain is not sexual, the sex is painful." [77] A woman who has allodynia of the vestibule because she has an increased density of nociceptors in the vestibular mucosa has the same disease process if she has pain when she wear tight clothing, if she has pain during intercourse, or if she has pain during both activities.

We do question some inclusions in the new definition. First, we cannot find relevant studies to support the seemingly arbitrary requirement that the symptoms of dyspareunia must occur at least 50% of the time. We believe a woman who has pain during intercourse one-third of the time should also be classified as having genito-pelvic pain. In clinical practice, we frequently see intermittent (and distressing) dyspareunia. Second, we do not see the necessity of including distress or interpersonal difficulty in the new definition. Although distress certainly increases a woman's suffering associated with her dyspareunia, it is not a necessary component of her dyspareunia. A woman that has increased density of c-afferent nociceptors in her vestibular mucosa still has pathology whether she is distressed by it or not. Just as we do not require a person with coronary artery disease to be distressed by his/her condition, we should not require a woman with dyspareunia to be distressed by it. Third, we recognize that hypertonus of the pelvic floor musculature may play a role in the development and/or maintenance of allodynia the vulvar vestibule and may be a frequent cause of dyspareunia [78,79]. However, the new definition still implies that this tightening only occurs during penetration (i.e., the former definition of vaginismus.) As thoroughly discussed by Binik, clear evidence of this reflex "tensing or tightening" is not clearly supported in the literature [67]. It is our belief from our collective vast clinical experience and from preliminary research [80] that the hypertonus of the pelvic floor muscles is not a reflexive act, but is a static condition. Therefore, we prefer that the new definition simply state, "Increased tone of the pelvic floor muscles is a frequent cause of, or contributor, to dyspareunia."

Finally, definition aside, we want to emphasize three very important facts: (i) we recognize that continued research is essential to determine the specific causes of painful sex; (ii) without a thorough revamping of the education provided to physicians and allied health care providers, the myth that dyspareunia is a psychological process will continue to be perpetuated; and (iii) that treatment by a multidisciplinary team comprised of knowledgeable and well-trained health care providers (physicians and/or nurse practitioners) women's health physical therapists, and psychologists/sex therapists is needed to address the biological, psychosocial, and sexual aspects of genito-pelvic pain [81].

Andrew Goldstein, MD*
Caroline Pukall, PhD†
Susan Kellogg, PhD‡
Lara Burrows, MD*
Pam Morrison, DPT§
Michael Krychman, MD¶
*The Center for Vulvovaginal Disorders, Washington, DC, USA; †Department of Obstetrics and Gynaecology and Kingston General Hospital, Queen's University, Kingston, Canada; ‡Pelvic and Sexual Health Institute, Philadelphia, PA, USA; §Pamela Morrison Physical Therapy P.C, New York, NY, USA; and ¶Sexual Medicine, Hoag Hospital, Newport Beach, CA, USA

"When you come to a fork in the road, take it" as Yogi Berra once said. While many women may have both desire and arousal problems, many others clearly have only one or the other. So why not have three categories, HSDD, FASD, and SIAD? Would this not offer the best options for patients and clinicians alike? As for pain disorders, every day researchers learn more about etiologies of sexual pain resulting in the need for more precise nomenclature, not merging all sexual pain disorders into one category. Take the fork—do not run the other way.

Medical treatment of women is as important as psychological treatment; therefore, assessments must be available that address both aspects of