**[From the Classifying Sex: Debating DSM-5 conference - for the attention of Véronique Mottier and Robbie Duschinsky]**

**Reconceptualising women’s sexual desire and arousal in DSM-5**

**Abstract**

The publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013 was the culmination of more than a decade of work by the American Psychiatric Association DSM-5 task force and Work Groups. In the area of sexual disorders, some of the most significant changes were made in diagnostic categories for female sexual dysfunction. The DSM-IV categories of desire and arousal disorders (*Hypoactive Sexual Desire Disorder* and *Female Sexual Arousal Disorder*) were replaced by a new, much broader diagnosis which included behavioural, subjective, and physical aspects of sexual experience (*Female Sexual Interest/Arousal Disorder*). Other major changes included the addition of more specific and stringent severity and duration criteria and a list of contextual factors e.g., partner factors, cultural/religious factors that should be assessed by clinicians before making a diagnosis. This article reviews the rationale behind these major changes and outlines the process and some of the key challenges/issues faced by the DSM-5 Sexual Dysfunctions subworkgroup in developing their recommendations.

*“Diagnostic categories are simply concepts, justified only by whether they provide a useful framework for organizing and explaining the complexity of clinical experience in order to derive inferences about outcome and guide decisions about treatment.”* (Kendell & Jablensky, 2003, p. 5)

In May, 2013 the first major revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM) since 1994 was published, the culmination of more than a decade of work by the American Psychiatric Association (APA) Task Force and 13 Work Groups (APA, 2013). There were some significant changes in the diagnostic categories and criteria sets for sexual disorders, particularly for female sexual dysfunctions.

This article outlines the background and rationale for the changes in the classification of female sexual dysfunctions introduced in DSM-5 (APA, 2013). The principles guiding the revision process, the stages in the development phase, and some of the key challenges faced by the Sexual Dysfunctions subworkgroup are presented. The major changes introduced in DSM-5 for female sexual dysfunctions are summarised and some recent critiques of the new criteria discussed.

**Historical aspects of the classification of female sexual dysfunctions**

 The first two versions of DSM published (DSM-I and DSM-II; APA, 1952, 1968) did not use the concept of “sexual dysfunction.” DSM-I listed “frigidity” and vaginismus in a list of supplementary terms in the manual and DSM-II only listed dyspareunia (pain during intercourse). In 1980, the concept of “psychosexual dysfunction” was introduced in the third edition of the DSM (APA, 1980), the term “psychosexual” reflecting the prevailing view at the time that psychological factors were of central importance in the etiology of sexual problems. The human sexual response cycle (HSRC) model put forward by Masters and Johnson (1966) was the framework underlying the classification of sexual dysfunctions, defined as “inhibitions in sexual desire or the psycho-physiological changes that characterize the sexual response cycle” (APA, 1980, p. 261). In the HSRC model, sexual response is conceptualized as a universal, linear series of phases – excitement, arousal, orgasm, and resolution – which are essentially the same in men and women; the model was later expanded to include the “desire” phase (Kaplan, 1974).

In DSM-IV (APA, 1994), the concept of “inhibition” no longer featured and psychosexual disorders were defined as characterized by “disturbance in sexual desire and in the psychophysiological changes that characterize the sexual response cycle” (p. 493). Another major change in DSM-IV was the inclusion of the distress criterion; the requirement that the problem causes “marked distress or interpersonal difficulty” was added to the criteria sets for all of the sexual dysfunctions. In addition to the main categories of female sexual dysfunction (desire, arousal, orgasm, and pain), DSM-IV also contained three additional categories: sexual dysfunction due to a general medical condition, substance-induced sexual dysfunction, and sexual dysfunction “not otherwise specified.”

**Perceived problems in DSM-IV**

There has been longstanding critique of the HSRC model as the framework for classifying sexual disorders (Tiefer, 1991), and of the assumption that women’s sexual problems should be conceptualized in a similar way to men’s (Segraves, Balon, & Clayton, 2007; Tiefer, 1991). Tiefer (1991) presented cogent evidence that the HSRC was “flawed from scientific, clinical, and feminist points of view.” (p. 20). Other problems identified in DSM-IV were the lack of any clear severity or duration criteria, leading to inflated prevalence rates of “female sexual dysfunction” (such as the oft-cited 43% figure; Laumann et al., 1999), inadequate recognition of partner and relationship factors (Tiefer, 1996), and an over-emphasis on genital response rather than subjective aspects of sexual arousal and desire (Graham, 2010). Since DSM-IV-TR [[1]](#footnote-1)(APA, 2000) various consultation groups and consensus panels have been convened to consider revisions of the DSM-IV-TR criteria e.g., the International Consensus Development Conference on Female Sexual Dysfunction (Basson et al., 2000, 2003), the second International Consultation on Sexual Medicine (Lue, Basson, Giulano, Khoury, & Montorsi, 2004), and the Working Group for a New View of Women’s Sexual Problems (Kaschak & Tiefer, 2001). With the exception of the New View classification system, most of the revisions recommended by these groups were relatively minor and all preserved the basic structure of the DSM, with discrete disorders linked to the desire, arousal, and orgasm phases of the HSRC. There has been some criticism about the fairly limited changes proposed by these expert panels as well as scepticism about the utility of “top down” consensus agreement (Bancroft, Graham, & McCord, 2001; King, Holt, & Nazareth, 2007; Mitchell & Graham, 2008).

DSM-IV-TR included two disorders related to arousal and desire problems in women: one, specific to women, Female Sexual Arousal Disorder (FSAD) and the other, Hypoactive Sexual Desire Disorder (HSDD), applied to both women and men. The essential criterion for a DSM-IV-TR diagnosis of HSDD was: “persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity” and in addition, as for all DSM-IV-TR diagnoses, there was a requirement that the “disturbance causes marked distress or interpersonal difficulty.” The focus on lack of sexual fantasies as an index of low sexual desire has been identified as problematic because many women report not having regular sexual fantasies (Cain et al., 2003) and in addition, the relationship between fantasies and sexual desire is uncertain e.g., some women report using fantasising to provoke sexual desire (Brotto, Heiman, & Tolman, 2009). The inclusion of lack of “desire for sexual activity” in the HSDD criterion has also been questioned, as women’s sexual desire is not always directed at having sexual activity (Meana, 2010) and there a myriad of non-sexual reasons that individuals engage in sex (Meston & Buss, 2007). In summary, then, multiple sources of evidence suggest the need for a broader conceptualization of sexual desire than simply fantasies and desire for sexual activity.

The essential criterion of the DSM-IV-TR diagnosis of FSAD was a “persistent or recurrent inability to attain or to maintain until completion of the sexual activity, an adequate lubrication swelling response.” In contrast to earlier versions of DSM (e.g., DSM-III), there was no mention of lack of subjective arousal or pleasure or of any non-genital changes associated with sexual arousal. The exclusive focus on lubrication as a primary marker of sexual arousal was problematic for many reasons, including the well-established low concordance between subjective feelings of arousal and genital response in women (Chivers, Seto, Lalumiere, Laan, & Grimbos, 2010) and the lack of evidence that most women with arousal disorder have impaired genital response (Brotto, Basson, & Gorzalka, 2004; Laan, van Driel, & van Lunsen, 2008). In addition, there is evidence that in clinical practice, very few women actually present with lack of lubrication as their primary sexual problem (Bancroft et al., 2001; Heiman, 2002; Meston & Bradford, 2007; Rosen & Leiblum, 1995); comorbidity between FSAD and HSDD is particularly high.

In addition to the specific critiques of these two specific disorders, broader criticisms of DSM-IV criteria for sexual dysfunctions were that there was no attempt to specify a minimum duration of symptoms (only the requirement that symptoms be “persistent and recurrent”) (Balon, 2008; Segraves et al., 2007), and no specification of a minimum frequency of range of settings, activities etc. in which the symptoms must occur. The marked comorbidity between DSM-IV arousal and desire disorders (Fugl-Meyer & Fugl-Meyer, 2002; Laumann et al., 1999) is problematic for a classification system based on a model of discrete disorders, each linked to different stages of the HSRC (Bancroft et al., 2001). Indeed, even before DSM-IV was published, some clinicians questioned whether FSAD should be retained as a diagnostic entity because of the infrequency with which women with FSAD presented for treatment (Segraves & Segraves, 1991); it seems that the diagnosis was retained in part to maintain the consistency between male and female diagnostic categories (the counterpart to FSAD in DSM-IV being Male Erectile Disorder).

In addition to the comorbidity between arousal and desire disorders as defined in DSM-IV, there is evidence of significant overlap between the constructs of arousal and desire. Qualitative studies have demonstrated that women often do not differentiate between sexual desire and arousal and even when they do, they do not experience these constructs in a uniform, temporal sequence (Beck, Bozman, & Qualtrough, 1991; Brotto et al., 2009; Goldhammer & McCabe, 2011; Graham, Sanders, Milhausen, & McBride, 2004; Mitchell, Wellings, & Graham, 2014). Experimental and clinical research on the Incentive Motivation Model (Laan & Everaerd, 1995; Laan & Janssen, 2007) also provides support for the idea that arousal and desire are not distinct phases of sexual response; as Laan and Both (2008) summarized, “there is no good reason to assume that feelings of desire and arousal are two fundamentally different things.” (p. 510). Finally, studies on the psychometric properties of questionnaire measures of sexual functioning, which have reported high correlations between desire and arousal domains (e.g., Dennerstein & Lehert, 2004; Wiegel, Meston, & Rosen, 2005) also provide support for the overlap between desire (for a review of these studies, see Brotto, Graham, Binik, & Segraves, 2011). In reviewing the literature on definitions of sexual desire, Meana (2010) concluded “The fact is that, currently there is no empirical basis for any of these distinctions between subjective arousal and desire” (p. 106) but she also noted that researchers and clinicians have continued to use these terms as if they are separate, distinct constructs.

**Development of DSM-5 Proposals for Female Sexual Dysfunction**

Early on in the DSM-5 revision process, the APA appointed Work Group Chairs, who invited members of their individual Work Groups, selected on the basis of their expertise in the particular area. Within a Work Group, subworkgroups were formed to focus on specific diagnoses; the sexual dysfunctions subworkgroup was one of three in the Sexual and Gender Identity Disorders Work Group. In addition, six cross-cutting “Study Groups” were formed, covering the topics of diagnostic spectra, lifespan developmental approaches, gender and cross-cultural issues, impairment assessment, and psychiatric/general medicine interface.

Since the publication of DSM-IV in 1994, the published scientific literature on sexual arousal and desire in women had grown exponentially and the first task of each of the subworkgroups was to complete comprehensive and critical reviews of the empirical literature for each of the specific DSM-IV disorders (for HSDD, see Brotto, 2010; for FSAD, see Graham, 2010). These reviews as well as input from DSM-5 advisors (researchers and clinicians selected by Work Group members) formed the basis for the initial DSM-5 proposals. At the beginning of the DSM-5 revision process, four principles were provided by the APA: the definitions/criteria should have clinical utility; recommendations must be guided by research evidence; and where possible, continuity with DSM-IV criteria should be maintained. In contrast to DSM-IV, however, there were no *a priori* constraints imposed on the degree of change from DSM-IV to DSM-5 (Kendler, Kupfer, Narrow, Phillips, & Fawcett, 2009).

After publication of the literature reviews, Work Groups developed the draft proposals, with feedback received from a number of sources, including the DSM-5 advisors, advocacy groups, APA committees and the Task Force members, and from public and professional comments to the draft proposals posted, at three different times during the revision process, on the APA website. Work Group members also presented the initial proposals at a number of professional meetings to elicit feedback from clinicians and researchers. The Scientific Review Committee (Kendler, 2013) evaluated the strength of the evidence for changes to DSM-IV criteria and the introduction/deletion of diagnoses. The Clinical and Public Health Committee reviewed proposed revisions to consider potential difficulties with clinical utility and the possible public health impact of the changes recommended. The APA Board of Trustees approved the final criteria for DSM-5 in late 2012.

Based on the critiques of DSM-IV, and the accumulated research findings on women’s experiences of sexual arousal/ desire and of sexual difficulties, our subworkgroup had some overarching “goals” in formulating the DSM-5 proposals. First, we wanted to place more emphasis on the *subjective* and *relational* aspects of women’s sexual experience and less on the genital aspects of sexual response and a greater acknowledgment of the variability in women’s sexuality. This focus led to the proposal to adopt a polythetic approach to diagnosis, in recognition of the fact that no one “model” of sexual response is likely to represent all women’s experiences (or, indeed, the different experiences of an individual woman) (Giles & McCabe, 2009; Sand & Fisher, 2007). A second goal was to avoid pathologizing normal variation in women’s experiences of desire and arousal. Many of the critiques of DSM-IV criteria were related to concerns about pathologizing short-term, often adaptive, changes in sexual functioning as “dysfunction” (Bancroft, Loftus, & Long, 2003). Some epidemiological surveys of sexual problems published over the last two decades have reported very high rates of female sexual “dysfunction” (e.g., Laumann et al., 1999; Witting et al., 2008), but there was also marked variability in prevalence rates, particularly for low sexual desire (Brotto, 2010). Moreover, there was increasing recognition that prevalence estimates varied dramatically depending on the time frame specified by researchers (Mercer et al., 2003) and on whether distress about the sexual problem was included in these estimates (Hayes, Dennerstein, Bennett, & Fairley, 2008). In particular, several studies suggested much lower prevalence rates of sexual problems when both low desire *and* distress were required (Dennerstein, Koochaki, Barton, & Grazziottin, 2006; King et al., 2007; Witting et al., 2008; for review, see Brotto, 2010). Finally, a third goal in developing the DSM-5 proposals was to “raise the bar” for diagnosis, given the previous very high rates of “dysfunction” reported in the literature. To avoid labelling short-term changes in sexual functioning as sexual “dysfunction,” it seemed important to specify some level and duration of symptoms that are required for a diagnosis, in addition to the symptoms being a significant change from what had previously been considered “normal” by an individual woman.

**Key Issues and Challenges**

In working on the proposals, there were a number of fundamental challenges experienced by our subworkgroup. The first, and arguably the most difficult, were definitional challenges. As Meana (2010) discussed, there have been many attempts to define sexual desire and arousal, but none of these has been satisfactory. We know little about the nature of sexual desire and in particular, what it is that we desire (Bancroft & Graham, 2011; Meana, 2010) or, as Meana stated, “desire for what by whom?.” There is also the issue of when a sexual problem should be classified as a “sexual dysfunction” (Bancroft et al., 2003).Distinguishing between psychiatric disorder and normal distress/variation has been a longstanding challenge in the mental health area generally (Wakefield, 2011).In the area of sexual functioning, two specific challenges are the recognition of the marked variability of women’s sexual expression (Bancroft & Graham, 2011) and the need to distinguish between transient problems in sexual functioning, which may be understandable and even adaptive reactions to current stressful circumstances, and more persistent problems. The need to avoid inappropriate pathologizing of what is normal variability in women’s sexual expression has been recognised for some time (Bancroft, 2002; Moynihan, 2003; Tiefer, 2001), but in view of continuing efforts to find pharmaceutical solutions for low desire and arousal problems, this remains a concern. In the deliberations of our Work Group, this consideration was a backdrop for the decisions made about diagnostic criteria; as Work Group members, we were cognizant of the potential implications of diagnostic criteria. As Michael First, a psychiatrist who was one of the editors of the DSM-IV-TR argued, in an article in the New York Times, “Anything you put in that book, any little change you make, has huge implications not only for psychiatry but for pharmaceutical marketing, research, for the legal system, for who’s considered ‘normal’ or not…” (Carey, 2010).

A second challenge was that of trying to effectively acknowledge the relational context of sexual problems in a classification system that is firmly based on an individual-centered definition of mental disorder. There is consistent evidence that relationship and partner factors are often of crucial importance to the etiology and experience of sexual problems (Bancroft et al., 2003; Heiman et al., 2007; King et al., 2007) and the DSM has been criticized for an “erasure of the relational context of sexuality” (Kaschak & Tiefer, 2001, p. 3). However, there are also some potential disadvantages of including “couple-level” problems as diagnostic entities. On the one hand, some have argued that problems related to discrepancies in sexual desire between sexual partners should not be diagnosed as a “disorder” because the system should not pathologize individuals on the basis of their relationship context (Segraves et al., 2007). On the other hand, if the goal is to produce a classification that is clinically meaningful, then this “couple-level” type of difficulty is important because it is such a common problem for which individuals seek help (Mitchell & Graham, 2008). Notwithstanding these complexities, our subworkgroup aimed to incorporate a better acknowledgment of the important role of relationship and partner factors in sexual difficulties.

A third challenge was the large and sometimes striking gaps in research on women’s sexual arousal/desire that our literature reviews revealed. One particular gap was the paucity of research on sexual problems experienced by women from non-Western countries (Meana, 2010). Although it seemed crucial to acknowledge the fact that the development of sexual problems can be heavily influenced by factors such as socio-cultural values, norms, and inadequate access to information or services (Kaschak & Tiefer, 2001), the lack of information about women in different cultures experiences of sexual arousal/desire hampered our ability to do this effectively.

**Major changes in DSM-5 for Female Sexual Dysfunctions**

 There were some significant changes made in DSM-5 to the diagnostic categories and the criteria sets for female sexual dysfunctions. One fundamental change was that male and female diagnostic categories are no longer “parallel” in DSM-5 and relatedly, the diagnostic categories are no longer underpinned by Masters and Johnson’s HSRC. This change is reflected in the new definition of sexual dysfunctions in DSM-5: “a group of disorders that are typically characterized by a clinical significant disturbance in a person’s ability to respond sexually or to experience *sexual pleasure*.” [italics added] (APA, 2013, p. 423). The previous references in the DSM-IV definition to “psychophysiological changes” and the “sexual response cycle” no longer feature in the DSM-5 definition; the reference to pleasure reflects our goal of putting greater emphasis on the subjective experiences of sexual desire/arousal and orgasm.

 A second major change in DSM-5 (implemented across all of the female and male sexual dysfunctions) was the addition of specific duration and severity criteria. There is now a requirement that the symptoms have persisted for a minimum duration of approximately six months and have been experienced on almost all or all (approximately 75% - 100% of) sexual encounters. The use of these minimum severity and duration criteria was intended to distinguish transient sexual difficulties from more persistent sexual problems. As in DSM-IV, all of the DSM-5 diagnoses require that the symptoms cause distress, although the wording has changed from “marked distress or interpersonal difficulty” (DSM-IV) to “clinically significant distress in the individual.”

 Regarding the arousal and desire-related disorders, both the FSAD and the HSDD diagnoses were deleted and one new disorder –“Female Sexual Interest/Arousal Disorder” (FSIAD) – was added. The definition of sexual desire was expanded to include behavioural, subjective, and physical aspects of desire/arousal. A polythetic approach, with a woman needing to meet *three* of *six* possible diagnostic criteria, has been adopted. The six criteria are: (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 on almost all or all (approximately 75%-100% of) sexual encounters; (5) absent/reduced sexual interest 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 on almost all or all (approximately 75%-100% of) sexual encounters. By using a polythetic approach, we wanted to recognize that desire/arousal problems are not experienced/expressed by women in a uniform manner. Many studies have supported the view that there is diversity in women’s (and men’s) experiences of sexual response (Carvalheira, Brotto, & Maroco, 2010; Janssen, McBride, Yarber, Hill, & Butler, 2008; Mitchell et al., 2014).

 DSM-IV-TR (APA, 2000) included a criterion that a sexual dysfunction not be better accounted for by another Axis 1 disorder and is not “due exclusively to the direct physiological effects of a substance...or a general medical condition.” As our Work Group questioned the possibility of ever establishing whether a sexual problem is due “*exclusively*” to one or another cause, this requirement was modified; all DSM-5 sexual dysfunctions include the following criterion: “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.” (p. 424) Also included in the accompanying text is the statement: “If the sexual difficulties are the result of inadequate sexual stimulation…a diagnosis of sexual dysfunction would not be made.” (p. 423)

 Similar to DSM-IV, subtypes for each sexual dysfunction are used to designate the onset and nature of the difficulty (Lifelong/Acquired; Generalized/Situational). The DSM-IV subtypes “Due to Psychological Factors” and “Due to Combined Factors” were eliminated in DSM-5; as discussed above, in practice it is difficult to ascertain etiology with any confidence and in many cases of sexual problems, both psychological and physical factors are involved (Basson & Weijmar Schultz, 2007). In addition to these subtypes, a list of five factors that may be relevant to etiology and/or treatment and hence should be considered during a clinical assessment is included (under “Associated Features Supporting Diagnosis”). These are: partner factors (e.g., partner’s sexual problems, health status, etc.); relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); individual vulnerability factors (e.g., poor body image, history of abuse); psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss); cultural/religious factors (e.g., attitudes towards sexuality); and medical factors relevant to prognosis, course, or treatment. These factors are similar to the “contextual descriptors” proposed by Basson et al. (2003) and to Bancroft’s (2009) “three windows approach” and provide a more contextual description of an individual woman’s sexual problems. Finally, new to DSM-5 is a requirement for the clinician to specify the severity of distress (mild/moderate/severe) the individual experiences in relation to the symptoms.

**Critiques of DSM-5 criteria**

 As mentioned above, during the revision process initial proposals for changes to DSM-IV diagnoses were available on the APA DSM-5 website and feedback was solicited from the public, as well as from clinicians and researchers across different disciplines. There were a number of responses to the proposed changes published in the *Journal of Sexual Medicine* and commentaries/letters to the editor published in the *Archives of Sexual Behavior*. Most of these related to the proposed deletion of HSDD and FSAD and the introduction of FSIAD (Balon & Clayton, 2014; DeRogatis, Clayton, Rosen, Sand, & Pyke, 2011) or to the likely implications of “raising the bar” for a diagnosis of female sexual dysfunction (Clayton, DeRogatis, Rosen, & Pyke, 2012a,b). Responses to these commentaries by our Work Group (Binik, Brotto, Graham, & Segraves, 2010; Brotto et al., 2011; Graham, Brotto, & Zucker, 2014) were also published.

 The published critiques focused on three primary concerns, the first of which appears to be based on a misunderstanding of the rationale/basis for introducing the new diagnostic category of FSIAD. Balon and Clayton (2014) argued that the primary reason for the creation of the diagnosis was “to dismantle the long-standing linear concept of the sexual response cycle…and to replace it with another concept of sexual response (circular model) for women.” However, the desire to abandon the HSRC was only one of many reasons presented for the FSIAD diagnosis (see Brotto, 2010 and Graham, 2010 for expanded discussion of the rationale). Basson’s (2000) model of sexual response did not “replace” the HSRC as a framework for the DSM-5 catgories; in fact, we did not privilege *any* one model of sexual response and one of the aims of using a polythetic approach in the diagnostic criteria for FSIAD was to avoid applying any “one size fits all” model of sexual response. Women experience and express sexual difficulties in varied ways and our diagnostic criteria reflect this diversity.

 A second concern expressed in some of the published critiques (Clayton et al., 2012a,b; Balon & Clayton, 2014) was that DSM-5 changes in diagnostic criteria (including the severity and duration criteria) will exclude women from receiving treatment. DeRogatis et al. (2011), for example, argued that “If women with HSDD according to DSM-IV-TR criteria would not qualify for a diagnosis of Sexual Interest/Arousal Disorder according to the proposed new classification, it raises the question of whether these women would receive *any diagnosis at all*, and thus whether they would be *excluded from consideration for treatment*.” (p. 218) [italics added]. As discussed above, one of the goals of our subworkgroup was to raise the threshold for diagnosis, given the very high rates of female sexual “dysfunction” reported in epidemiological studies (e.g., Laumann et al., 1999). In the DSM-5 text, we make the distinction between individuals presenting with sexual problems where there may be a “need for care” but where a diagnosis of sexual dysfunction would not be made e.g., in cases where lack of knowledge about effective stimulation might impair arousal or orgasm (APA, 2013, p. 423). It is likely that the concern about women being excluded from treatment is principally a concern about the impact of the revised criteria on the reimbursement for treatment from U.S. insurance companies (Balon & Clayton, 2014) and on the approval of *pharmaceutical* treatments, as DSM-IV criteria were used to select samples of women in on-going large-scale clinical trials.

A third, more amorphous concern expressed is that in some undefined way, there is the potential for the new DSM-5 criteria to “inflict harm” and to “create havoc in the entire area of sexual dysfunction” (Balon & Clayton, 2014). While it has been difficult to identify exactly what harm and havoc is anticipated, underlying these critiques is the concern that the DSM-5 does not “offer any cogent diagnostic continuity …from DSM-IV” (Balon & Clayton, 2014). The idea that DSM-IV diagnostic categories should be preserved to maintain continuity in research and clinical practice has driven many of the previous attempts to revise the DSM-IV classification of female sexual dysfunction (e.g., Basson et al., 2000; Segraves et al., 2007). This desire for continuity with the traditional categories of discrete desire, arousal, and orgasm disorders has resulted in a reluctance to “return to the drawing board” (Mitchell & Graham, 2008), despite the fact that research has consistently demonstrated that these traditional categories of sexual response do not fit the experiences of many women. The authors of the above critiques do not acknowledge the widespread dissatisfaction, from both clinical and research perspectives in the DSM-IV criteria for female sexual dysfunction; as Rutter (2011) commented, “the criterion that any proposed changes must include justifications is misleadingly one-sided. It is equally necessary to justify why an outmoded system should be retained” (p. 648).

**Conclusions**

While the new DSM-5 classification system for female sexual dysfunction is an improvement over the unidimensional and genital-focused DSM-IV diagnoses of HSDD and FSAD, and one that will hopefully facilitate better clinical practice and research, it is important to acknowledge that there is still much work to be done. There is a need for research on the validity, reliability, and clinical utility of the FSIAD diagnostic criteria; unfortunately, no APA funding was provided for field trials of the criteria for any of the sexual disorders. Moreover, a number of other changes that were considered by our subworkgroup were not implemented, in part because of the lack of research on various topics; in fact, the work done leading up to DSM-5 highlighted these gaps in research on women’s sexuality. For example as there is overlap not just between desire and arousal, but also significant comorbidity between desire, arousal, and orgasm, some researchers have argued that there should be a *single* category of sexual response problem (Laan, Brauer, & van Lunsen, 2003; Tiefer, 2009). The New View Classification system of women’s sexual problems makes no distinction between any specific types of sexual problems, defining sexual problems as “discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience” (Kaschak & Tiefer, 2001, p. 5). The possibility of merging Female Orgasmic Disorder with FSIAD was considered by our subworkgroup (Binik et al., 2010), but in contrast to the research on the overlap between desire and arousal, there was much less research supporting the overlap between desire/arousal problems and orgasm difficulties.

In summary, the DSM-5 definitions of female sexual dysfunction better reflect the reality of women’s experiences of sexual problems and the variability in women’s sexual response, both within and across women. It is important, however, to carefully assess the clinical and research utility of the new criteria and to avoid the “inevitable reification” that occurs when new diagnostic conceptual approaches become established (APA, 2013, p. 9).

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1. A text revision of the DSM-IV (DSM-IV-TR) was published in 2000. The diagnostic categories and most of the diagnostic criteria were unchanged from DSM-IV, but some of the text was revised. [↑](#footnote-ref-1)