Two challenges for the classification of sexual dysfunction

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Abstract

Introduction. The current classification of sexual function (in particular, the Diagnostic and Statistical Manual of Mental Disorders, DSM IV) has lately attracted significant criticism at both research and clinical levels. Despite this, there has been a reluctance to return to the drawing board. Instead, attempts to improve the system have been marginal, constrained by the need to secure professional consensus, the desire for continuity with traditional categories, and the emphasis on diagnostic agreement (reliability).

Aim. In this paper we examine two key challenges currently faced by the DSM: how to effectively acknowledge the relational context of sexual problems and how to avoid pathologising normal variation.

Results. We raise some possible new directions, such as ways in which relational processes could be integrated into the current system, and possibilities for introducing a dimensional rather than categorical model of sexual function.

Conclusions. We argue that if the next version of DSM (version V) is to avoid the weaknesses inherent in the present system, then a return to the drawing board is precisely what is required.

Introduction

Classification systems impose meaning and structure upon complex phenomena and, where officially sanctioned, create a common language for the advancement of knowledge. Since 1952, sexual function problems have been classified under the rubric of mental health, in which the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD) prevail as officially sanctioned classification systems [1,2]. The purposes of these diagnostic systems are to facilitate communication among professionals, help clinicians determine which particular disorder is present and guide treatment decisions and research; in the U.S., the DSM also provides the basis for reimbursements to insurance companies. Many authors have argued that current classification systems fall far short of the above goals. Indeed it has been suggested that DSM criteria have hampered research into the etiology, pathophysiology, and treatment of mental disorders [3,4,5]. The DSM system for classifying sexual disorders has not escaped these criticisms, particularly in recent years [6,7].

The concept of “psychosexual dysfunction” first appeared in the third edition of the DSM (DSM-III) [8]. Grounded in the work of Masters and Johnson, Lief and Kaplan, the classification is based on a biomedical model of sex comprising three temporal stages: desire, arousal and orgasm [9,10,11]. Since 1980, several revisions of the DSM have reflected advances in research coupled with ongoing debate concerning the nature of sexual difficulties. Also, since the latest version [1], various panels have met to suggest further revisions: the National Institutes of Health Consensus Development Conference on Impotence, the International Consensus Development Conference on Female Sexual Dysfunction and the second International Consultation

on Sexual Medicine [12,13,14]. However, there have been no paradigm shifts and most of the suggested revisions have been minor [15], what Carson earlier described as "…more tinkering on a superficial level with operational diagnostic criteria that tend over time to approach the status of revealed truths" [3, p. 304].

A particular barrier to substantive change has been the requirement that there be substantial empirical data before modifications can be considered [16]. Attempts to ground the DSM in empirical research date back to DSM-III [3]; however, in practice it seems that maintaining "continuity" with the classification system in place may sometimes take precedence over research evidence. Segraves and colleagues provided an example of this in the work leading up to DSM-IV [16]. A literature review suggested that the subjective criteria for female arousal disorder be retained. The DSM-IV work group overruled this in order that the DSM-IV diagnosis be similar to the ICD-9 criteria and "to maintain male-female similarity in diagnostic categories" [16, p. 569], a key feature of the DSM IV nosology. The process by which the DSM is compiled may also present barriers to substantive change; in particular, the selection of DSM working group and task force members and the need for consensus. For example, lack of "satisfactory consensus" was one of the key reasons that "sexual satisfaction disorder" failed to be introduced as a new category following deliberations of the International Consensus Development Conference on Female Sexual Dysfunction. This occurred despite a majority in favour and despite the relevance of the category to a significant proportion of women seeking help for sexual problems [13]. It is noticeable that much of the "tinkering" has been towards increasingly precise operational criteria designed to provide quantitative end points for clinical trials and clear-cut delineations for insurance companies. This is not

surprising, given the lack of non-clinical representation on consensus panels, and pervasive links between panellists and the pharmaceutical industry [15, 17-19].

As preparations for DSM-V step up, suggestions for improving the system are being brought to the table. Segraves and colleagues [16] recently proposed that DSM-V include specific criteria related to duration and severity of symptoms, in order to avoid labelling transient (and possibly adaptive) alterations in sexual function as "sexual dysfunction" [20]. These seem reasonable suggestions and ones that have some empirical support [21, 22]. However, in our view there are also a number of more fundamental issues that need to be addressed in the next revision.

Working from this premise, we examine two challenges that have been the source of much debate: (1) How do we effectively acknowledge the relational context of sexual problems? and (2) How do we best avoid pathologising normal variation? In the context of this debate, we aim to provide some possible directions for a revised classification system of sexual problems.

How do we effectively acknowledge the relational context?

Relationship factors – the sexual partner as well as the interaction between partners – are often fundamental to the etiology and experience of sexual difficulties [23]. This fact is well supported by empirical evidence [20,24,25]. A recent British study showed that between half and two thirds of women thought that difficulties with their partner lay at the base of their sexual problems [26]. We also know that co-morbidity of sexual problems in partners is common, and that when one partner receives individual therapy for a sexual problem, there is often also improvement in sexual functioning for the other partner [27-29]. There is increasing recognition that medications such as PDE-5 inhibitors may prove ineffective if significant relationship issues are not also dealt with and there has been a related interest in combining

medical and sex therapy approaches to treatment [30, 31]. In practice, the relational context is almost always a central focus of clinical therapy for problems [32].

Given this evidence and the realities of clinical management, it is puzzling that the possibility of formally acknowledging relational components within the classification system does not appear to have been seriously considered [33]. In fact recent proposals to revise DSM have, if anything, placed even more emphasis on the individual rather than the couple. For instance, the International Consensus Group on Female Sexual Dysfunction recommended replacing the DSM criterion of "marked distress and interpersonal difficulty" with "personal distress" [13]. More recently, Segraves et al. recommended, "decrease in desire related to …discrepancies in sexual desire between sexual partners, should not be diagnosed as desire disorders" [16, p. 576]. The ostensible rationale for both of these recommendations was that the system should not pathologise individuals on the basis of their relationship context.

To an extent, the case made by Segraves and colleagues is persuasive: discrepancies in desire should not result in the partner with the lower level being labelled as "dysfunctional". But the mismatch itself can be seen, at a systems level, as a problem belonging to the "interactional dynamics of the couple" [34, p. 243]. In fact, it has long been recognised that within couples, the assessment of desire is relative; individuals make judgments about their level of desire primarily in comparison with the level of their partner [35]. If we are interested in a classification that is *clinically meaningful*, then this couple-level dysfunction is important because it is such a common problem for which individuals seek help. Clement questioned whether sexual desire might be more usefully construed as an "emergent function of the structural matching of partners" than as an individual trait [34]. Relevant here is the large body of literature on "relational disorders", defined as "persistent and

painful patterns of feelings, behavior, and perceptions involving two or more partners in an important personal relationship" [36, p. 161]. Work is being done to develop diagnostic criteria for relational disorders such as marital conflict disorder and marital abuse disorder [37]. In a similar vein, it may be worth exploring the possibility of an additional sub-category of sexual disorder where the focus is primarily relational.

Incorporating relational processes need not imply as radical a step as the creation of new categories. Although the DSM highlights relational processes in the V codes and in some of the supplemental materials, "currently relational problems are poorly described…and not very useful for clinical or research purposes" [38, p. 360]. In response to this, various authors have discussed the possibilities for integrating relational issues into DSM [36-40]. For instance, Beach and colleagues suggested that reference to the presence or absence of specific relational processes associated with a sexual disorder could be made via "relationship specifiers" [38, p. 364]. Specifiers are usually used to "describe the course of the disorder or to highlight prominent symptoms" or to "indicate associated behavioural patterns of clinical interest" [38, p. 364]. Alternatively, relationship patterns of relevance could be elaborated as part of the symptom criteria for the disorder.

A third approach to acknowledging the relational and cultural contexts of sexual problems is to develop a classification system that is based on etiology of sexual difficulties, rather than discrete categories of symptoms. Such an approach has been put forward by the "New View of Women's Sexual Problems" developed by an independent group of clinicians and social scientists [41]. This classification system incorporates a woman-centred definition of sexual problems (as "discontent or dissatisfaction with any emotional, physical, or relational aspects of sexual experience") and provides four categories of causes, including socio-cultural,

political, or economic factors, partner and relationship factors, psychological factors, and medical factors.

All of the above approaches would require further research and elaboration, but in our view they have the potential to rectify DSM's problematic "erasure of the relationship context in DSM" [41]. Without such fundamental shifts in thinking, we will continue to get tied up in knots trying to classify an inherently relational act in purely individual terms.

What is the best way to avoid pathologising normal variation?

Establishing the boundary between normal and pathological has always been a key issue and is still being raised with respect to the next edition of the DSM [42]. This is a similar challenge to that faced by mental health practitioners in deciding when 'sad' becomes 'depressed'.

Some argue that more reliable cut-off points could be established if there was sufficient normative data. This lack is frequently bemoaned but what little data we have actually suggests substantial variability in sexual interest and behavior across age, gender, cultural context and sexual orientation [43-45]. For instance, the variability with which women experience desire and arousal (and indeed whether these constructs are separable) has posed an ongoing headache for the classification of female desire and arousal disorders [7, 46-48]. Given this variation, and the fact that what counts as normal is so culturally dependent, attempts to define normal need to be met with extreme caution [43].

Against this background, at least three strategies have been proposed to avoid pathologising this normal variation. We discuss each in turn.

One option that is increasingly fashionable is to aim for precise and evidence-based cut off points using what normative data is available. An example is the

recently proposed cut-off point of 1.5 minutes intravaginal ejaculation latency time (IELT) in the diagnosis of premature ejaculation (PE) [49]. Thus ejaculations deemed 'too quick' by men themselves (or their partners) but that occur longer than 1.5 minutes after penetration, are construed as normal variation. The difficulty with precise cut-off criteria is that it feeds an unhelpful obsession with a particular criterion of 'health' (in this instance, time to ejaculation) and might risk measuring 'performance' according to this indicator. If we accept that some men are 'designed' to come sooner than others (in the same way that some men are better at sprinting and others at long-distance running), then it is harder for some men to 'achieve' the cut-off point than others. Given the association between performance anxiety and PE, do we want to (further) encourage men to think about their sexual life as governed by a stopwatch? On a more practical level it is questionable how feasible it would be to use such precise criteria in clinical settings.

A second option is to specify distress as a necessary, but not sufficient, criterion for diagnosing dysfunction. "Marked distress or interpersonal difficulty" is currently an essential criterion for any DSM diagnosis of sexual dysfunction and distress or disability is a necessary condition for the diagnosis of all psychiatric disorders [1]. But this criterion was apparently added in haste, and with insufficient consultation, to DSM-IV and has been the source of controversy ever since [16].

The issue of whether distress should be a criterion for classification, unless it is contributing to the problem (e.g., 'performance anxiety' contributing to erection difficulties), is a difficult one. On the one hand, if we accept that sex is an inherently psychosocial act, essentially variable, primarily relational, and influenced as much by culture as by biology, then it would seem to follow that if individuals do not see themselves as having a problem, they cannot be deemed by others to do so. The

problem is that the distress itself is influenced by socio-cultural factors such as the expectations of a partner or messages from the media.

Furthermore, we know that some individuals with sexual dysfunction are not distressed by it. Studies that have measured distress have found that only a proportion of women with sexual difficulties (up to two-thirds) also report distress [50]. In one national survey of women that examined distress about sexual relationships, the best predictors of distress were general emotional well-being and emotional relationship with partners [20]. In contrast, DSM-related physical aspects of sexual functioning, such as lubrication and orgasm, were poor predictors, suggesting that distress may be more closely associated with relationship quality than with physical function. A recent qualitative study suggested that the degree of distress might be affected by a wide range of factors including the perceived cause of the problem and the reaction of the partner [51].

A study by Oberg and colleagues demonstrated that from an epidemiological standpoint, measuring dysfunction *per se* versus dysfunction plus distress[1] results in only moderately lower prevalence rates for the latter [22]. They suggested that the more significant distinction is between the reporting of mild (defined as “hardly ever” or “quite rarely”) versus manifest (“quite often”; “nearly all the time”; and “all the time”) symptoms/and or distress; mild symptoms, because they are so common, might be considered ‘normal’ variation as opposed to a clinical condition. The importance of specifying duration and intensity of symptoms has been discussed earlier [16].

Clearly, anyone who is not distressed or troubled is unlikely to seek treatment and clinically, it is important to assess the degree of distress engendered by a problem. However, logically it seems that lack of distress should not exclude a problem from a

[1]I.e., comparing the A and B categories to differentiate dysfunction from its emotional impact.

diagnostic category, even if it means that the non-distressed individual does not wish treatment. It would also seem important that research into the etiology, course, and prognosis of individuals with sexual dysfunction include individuals in this latter group as well as those who are motivated to seek help for a problem.

We would agree with the views of Althof [52], and Segraves and colleagues [16] that personal or interpersonal distress should not be a requirement for the diagnosis of sexual dysfunction. One possibility, suggested by Althof [52], is that distress be included as a "specifier", rather than an essential criterion for diagnosis. Other specifiers might indicate developmental or biological features of a disorder.

A third option is to use a dimensional model of classification of sexual disorder rather than a categorical one. The former views sexual dysfunction as "arbitrary distinctions along dimensions of functioning"; whilst the latter views them as "discrete clinical conditions" [53, p. 211]. In a categorical system, a 'case' is an individual who meets the criteria for the attribute; using a dimensional model, 'caseness' is a matter of degree, and a 'cut-off' point may be imposed, depending on circumstance [54]. A dimensional system avoids the need to claim distinct boundaries between normal and pathological and gets around the problem of overlap between diagnostic categories.

The question of whether a dimensional model should supplant the categorical perspective used in the DSM is a longstanding issue but one that seems to be gaining momentum [3,36,53, 55]. At the 2007 Annual Meeting of the American Psychiatric Association, a symposium was held on the feasibility of adding dimensions as well as categories of mental disorders to DSM-V. It was noted that the purpose of a diagnostic system such as the DSM is not to say what is "normal" or "acceptable" but to describe the presentation of an individual who comes to get clinical help [56]. The

debate around a categorical vs. dimensional classification system seems highly relevant to the debate around medicalization of sexual problems [15]. However, it is interesting that, again, there have been no proposals for using a dimensional model of sexual functioning as a possible basis of classification of sexual disorders in DSM.

Part of the reluctance to consider dimensional classification stems from a fear that it is less clinically useful [53]. Yet the current categorical system has been criticised for its weak clinical utility, both in predicting the best form of treatment or the prognosis [15,43,57]. It has been described as "a list of symptoms not necessarily synonymous with diagnoses" [58, p. 131]. As Carson argued, "the notion that the patient may simultaneously harbour a plurality of separate diagnoses with considerable feature overlap seems on its face to involve enormous classificatory difficulties" [3, p. 303].

Finally, a strong argument in favour of a dimensional rather than categorical model is the fallacy of the 'one model fits all' idea. This was amply demonstrated in a recent study by Sand and Fisher [59] in which a community sample of women, when asked which best represented their own sexual experience, were equally likely to endorse each of three different current models of sexual response – those of Masters and Johnson, Kaplan and Basson [9,11,47]. The findings underline the heterogeneity of women's sexual response and highlight the need for more research into how women (and men) themselves actually experience sexual problems. The presumption that the current DSM categorical system represents an underlying "model" of sexual response that is uniform across and within individuals, is a likely source of many of its shortcomings and lack of clinical utility. Although the Sand and Fisher study had limitations e.g., the descriptions of the models were fairly brief, it is one of few studies that has employed such a 'bottom-up' approach and is a refreshing alternative

to the "consensus" conferences that have required expert members to reach agreement about recommendations for diagnostic criteria.

Conclusions

In summary there has been a lack of progress in refining and improving the criteria for diagnosing sexual dysfunction which we would argue has less to do with lack of empirical data and more with a deep-seated reluctance to "go back to the drawing board". It is interesting that although there are some fairly radical suggestions for changes in classifying other psychiatric disorders [e.g., 37,39], most of the suggestions for revising the classification of sexual disorders have been comparatively modest.

In the introduction we stated that the purposes of the DSM are to facilitate communication among professionals, help clinicians determine which particular disorder is present, guide treatment decisions and research and, in the U.S., provide the basis for reimbursements to insurance companies. We suggest that a dimensional classification system, which includes relational aspects as one dimension, may facilitate a valid conceptualisation, enabling clinicians to understand, treat and research difficulties holistically and in context. It would also facilitate dialogue across disciplines by formally requiring clinicians to consider dimensions beyond their immediate clinical focus and by avoiding the unhelpful split between psychosocial and biomedical perspectives. It may also simplify reimbursement procedures by avoiding plural and over-lapping diagnoses.

Our aim in this article was neither to present a new classification scheme nor to suggest new diagnostic criteria for DSM-V categories of sexual dysfunction. Instead we wanted to raise some possible "new directions" for conceptualizing sexual problems (e.g., as relational disorders, or using a dimensional model) that warrant

serious consideration. Although much work would need to be done to develop the possibilities we have raised (in particular much further research) and there is bound to be reluctance to consider such changes, the outcome might be a classification system of sexual problems that would be useful for both clinical practice and research.

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References

1 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, (4th edition) (DSM-IV-TR). Washington, DC: American Psychiatric Association; 2000.

2 World Health Organization. ICD-10: International Statistical Classification of Diseases and Related Health Problems, 10th ed. Geneva: World Health Organisation; 1992.

3 Carson RC. Dilemmas in the pathway of the DSM–IV. J Abnorm Psychol 1991;100:302–7.

4 Kendell R, Jablensky, A. Distinguishing between the validity and utility of psychiatric diagnoses. Am J Psychiatry 2003;160:4-12.

5 Hyman S. Forward. In: Phillips K, First M, and Pincus H, eds. Advancing DSM: Dilemmas in Psychiatric Diagnosis. Arlington, VA: American Psychiatric Association; 2003: xi-xix.

6 Tiefer L. Historical, scientific, clinical and feminist criticisms of "The human sexual response cycle" model. Annu Rev Sex Res 1991;2: 1-23.

7 Tiefer L. A new view of women's sexual problems: Why new? Why now? J Sex Res 2001:38;89–96.

8 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (3rd edition) (DSM-III). Washington, DC: American Psychiatric Association; 1980.

9 Masters WH, Johnson VE. Human sexual response. Boston: Little, Brown, & Co.; 1966.

10 Lief HI. Inhibited sexual desire. Med Asp Hum Sex 1977;7:94-5.

11 Kaplan HS. The new sex therapy. New York: Brunner/Mazel; 1974.

12 NIH Consensus Development Panel on Impotence. Impotence. JAMA 1993;270:83-90.

13 Basson R, Berman J, Burnett A, Derogatis L, Ferguson D, Fourcroy J, Goldstein I, Graziottin A, Heiman J, Laan E, Leiblum S, Padma-Nathan H, Rosen R, Segraves K, Segraves RT, Shabsigh R, Sipski M, Wagner G, Whipple B. Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and classifications. J Urol 2000;163: 888–93.

14 Lue T, Basson R, Rosen R, Giuliano F, Khoury S, Montorsi F, eds. Sexual medicine: Sexual dysfunctions in men and women. Paris: Health Publications; 2004.

15 Bancroft J, Graham CA, McCord C. Conceptualizing sexual problems in women. J Sex Marital Ther 2001;27:95-103.

16 Segraves R, Balon R, Clayton A. Proposal for changes in diagnostic criteria for sexual dysfunctions. J Sex Med 2007;4:567-80.

17 Hall M. Small print and conspicuous omissions: Commentary on the “FSD” classification report. J Sex Marital Ther 2001;27:149-50.

18 Shaw J. Another procrustean bed for female sexual functioning. J Sex Marital Ther 2001;27:211-14.

19 Tiefer L. The “consensus” conference on female sexual dysfunction: Conflicts of interest and hidden agendas. J Sex Marital Ther 2001;27:227-36.

20 Bancroft J, Loftus J, Long JS. Distress about sex: A national survey of women in heterosexual relationships. Arch Sex Behav 2003;32:193–208.

21 Mercer CH, Fenton KA, Johnson AM, Wellings K, MacDowell W, McManus S, Nanchahal K, Erens B. Sexual function problems and help seeking behaviour in Britain: National probability sample survey. BMJ 2003;327:426-7.

22 Oberg K, Fugl-Meyer A, Fugl-Meyer K. On categorization and quantification of women's sexual dysfunctions: An epidemiological approach. Int J Impot Res 2004;16:261-69.

23 Fisher WA, Rosen RC, Eardley I, Sand M, Goldstein I. Sexual experience of female partners of men with erectile dysfunction: The female experience of men's attitudes to life events and sexuality (FEMALES) study. J Sex Med 2005;2:675-84.

24 Dennerstein L, Lehert P, Burger H, Dudley E. Factors affecting sexual functioning of women in the midlife years. Climacteric 1999;2:254–62.

25 Ellison C. Women's sexualities. Oakland, CA: New Harbinger; 2000.

26 King M, Holt V, Nazareth I. Women's views of their sexual difficulties: Agreement and disagreement with clinical diagnoses. Arch Sex Behav 2007; 36:281-8.

27 Nobres P, Pinto-Gouveia J, Gomes FA. Prevalence and comorbidity of sexual dysfunctions in a Portuguese clinical sample. J Sex Marital Ther 2006;32:173-82.

28 Segraves K, Segraves RT. Hypoactive sexual desire disorder: Prevalence and comorbidity in 906 subjects. J Sex Marital Ther 1991;17:55-8.

29 Heiman J, Talley D, Bailen J, Oskin T, Rosenberg S, Pace C, Creanga D, Bavendam T. Sexual function and satisfaction in heterosexual couples when men are administered sildenafil citrate (Viagra®) for erectile dysfunction: a

multicentre, randomised, double-blind, placebo-controlled trial. BJOG 2007;114:437–47.

30 Rosen RC. Erectile dysfunction: Integration of medical and psychological approaches. In: SR Leiblum, ed. Principles and Practice of Sex Therapy. Fourth ed. NY: Guildford Press; 2007:277-312.

31 Riley A. Commentary on Rowland's article. J Sex Marit Ther 2007;33:461-6.

32 Graham CA, Bancroft J. The sexual dysfunctions. In: Gelder M, Lopez-Ibor, J, Andreasen N, and Geddes J, eds. New Oxford textbook of psychiatry. 2nd edition. Oxford: Oxford University Press; 2007: in press.

33 Tiefer L. The medicalization of sexuality: conceptual, normative, and professional issues. Annu Rev Sex Res 1996;7:252-82.

34 Clement U. Sex in long-term relationships: A systemic approach to sexual desire problems. Arch Sex Behav 2002; 31:241-6.

35 Zilbergeld B, Ellison CR. Desire discrepancies and arousal problems in sex therapy. In: Leiblum SR, Pervin LA, eds. Principles and practice of sex therapy. New York: Guilford Press; 1980:66-104.

36 First MB, Bell CC, Cuthbert B, Krystal JH, Malison R, Offord DR, Reiss D, Shea MT, Widiger T, Wisner KL. Personality and relational disorders: A research agenda for addressing crucial gaps in DSM. In: Kupfer DJ, First, MB, Regier, DA, eds. A research agenda for DSM-V. Washington DC: American Psychiatric Association; 2002:123-199.

37 First M. Relational processes in the DSM-V revision process: Comment on the special section. J Fam Psychol 2006;20:356-8.

38 Beach SRH, Wamboldt MZ, Kaslow NJ, Heyman RE, Reiss D. Describing relationship problems in DSM-V: Toward better guidance for research and clinical practice. J Fam Psychol 2006;20:359-68.

39 Denton WH. Issues for DSM-V: Relational diagnosis: An essential component of biopsychosocial assessment. Am J Psychiatry 2007;164:1146-7.

40 Kaslow FW. History, rationale, and philosophic overview of issues and assumptions. In: Kaslow, FW, eds. Handbook of relational diagnosis and dysfunctional family patterns. New York: John Wiley;1996:3-18.

41 The Working Group for a New View of Women's Sexual Problems. A new view of women's sexual problems. In: Kaschak E, Tiefer L, eds. A new view of women's sexual problems. New York: The Haworth Press; 2001:1-8.

42 Balon R, Segraves RT, Clayton A. Issues for DSM-V: Sexual dysfunction, disorder, or variation along normal distribution: Toward rethinking DSM criteria of sexual dysfunctions. Am J Psychiatry 2007;164:198-200.

43 Potts A, Bhugra D. Classification and sexual disorders. Int Rev Psychiatry 1995;7:167-74.

44 Laumann EO, Nicolosi A, Glasser DB, Paik A, Gingell C, Moreira E, Wang T. Sexual problems among women and men aged 40-80 years: Prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. Int J Impot Res 2005;17:39-57.

45 Lippa RA. The relation between sex drive and sexual attraction to men and women: A cross-national study of heterosexual, bisexual, and homosexual men and women. Arch Sex Behav 2007;36:209-22.

46 Rosen R, Brown C, Heiman J, Leiblum S, Meston C, Shabigh D, Ferguson D, D'Agostino Jr. R. The Female Function Index (FSFI): A multidimensional self-

report instrument for the assessment of female sexual function. J Sex Marital Ther 2000;26:191-208.

47 Basson R. The female sexual response: A different model. J Sex Marital Ther 2000;26:51-64.

48 Graham CA, Sanders SA, Milhausen R, McBride K. Turning on and turning off: A focus group study of the factors that affect women's sexual arousal. Arch Sex Behav 2004;33:527-38.

49 Waldinger MD, Schweitzer DH. Changing paradigms from a historical DSM-III and DSM-IV view toward an evidence-based definition of premature ejaculation. Part II. Proposals for DSM-V and ICD-11. J Sex Med 2006;3:693-705.

50 Hayes RD, Bennett C, Fairley CK, Dennerstein L. What can prevalence studies tell us about female sex difficulties and dysfunction? J Sex Med 2006;3:589-95.95

51 Mitchell K, Wellings K, King M, Nazareth I, Johnson A. Taking it personally: Understanding the variation in responses to sexual difficulties. World Association for Sexual Health 18th Congress. Sydney 2007: Abstract 034-7.

52 Althof S. My personal distress over the inclusion of personal distress. J Sex Marital Ther 2001;27:123-5.

53 Widiger TA. A dimensional model of psychopathology. Psychopathology 2005;38: 211-14.

54 Devins G. Psychiatric rating scales. Paper presented at the Clarke Institute of Psychiatry, Toronto, Ontario; 1993.

55 Widiger TA, Samuel DB. Diagnostic categories or dimensions? A question for the Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition. J Abnorm Psychol 2005;114: 494-504.

56 Busko M. Why dimensional as well as categorical diagnoses are not needed in DSM-V. Medscape Medical News, available at http://www.medscape.com/viewarticle/558395; 2007.

57 Bancroft J. Human sexuality and its problems. Oxford, UK: Elsevier; in press.

58 Davis S. An external perspective on the report of the International Consensus Development Conference on Female Sexual Dysfunction: More work to be done. J Sex Marital Ther 2001;27:131-133.

59 Sand M, Fisher WA. Women's endorsement of models of female sexual response: The nurses' sexuality study. J Sex Med 2007;4:708-719.