Should Dyspareunia Be Retained as a Sexual Dysfunction in DSM-V? A Painful Classification Decision

Yitzchak M. Binik, Ph.D. 1,2

The DSM-IV-TR (American Psychiatric Association, 2000) classifies dyspareunia as a sexual dysfunction and describes it as a “sexual pain” disorder. This classification has been widely accepted with little controversy despite the absence of a theoretical rationale or supporting empirical data. An examination of the validity of this classification suggests that there is little current justification for the use of the term “sexual pain” or for considering dyspareunia a sexual dysfunction. Dyspareunia fits the current DSM-IV-TR classification criteria for pain disorder better than it fits those for sexual dysfunction. Empirical data from diagnostic, experimental, and therapy outcome studies support this conclusion. The reconceptualization of dyspareunia as a pain disorder rather than as a sexual dysfunction has important implications for the understanding and treatment of this prevalent but neglected women’s health problem.

KEY WORDS: DSM; dyspareunia; pain disorder; sexual dysfunction.

INTRODUCTION

There is almost no controversy today concerning the classification of dyspareunia as a sexual dysfunction. Both the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) and the International Classification of Disease (WHO, 1992) include dyspareunia in their sections on sexual dysfunction and specifically define it with respect to sexual intercourse. The DSM-IV-TR (2000) defines dyspareunia in the following way:

A. Recurrent or persistent genital pain associated with sexual intercourse in either a male or a female.
B. The disturbance causes marked distress or interpersonal difficulty.
C. The disturbance is not caused exclusively by vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Like all sexual dysfunctions, dyspareunia is subtyped as “lifelong or acquired” as “generalized or situational” and as “due to psychological or combined factors.” Even when there is a presumed underlying physical cause, the DSM classifies dyspareunia as a “sexual dysfunction due to a general medical condition.” Although there has been much controversy concerning the definition of other sexual dysfunctions in women (e.g., desire and arousal), recent consensus conferences (e.g., Basson et al., 2000) have not seriously challenged the classification of dyspareunia.

In my view, the definition and diagnostic criteria for dyspareunia make little sense and should be scrapped. Although a proposal to discard an established category may be perceived as needlessly radical, I will argue on both empirical and theoretical grounds that it is justified. Furthermore, I will propose that what is called dyspareunia today can be more usefully re-conceptualized as a group of different “urogenital pain disorders.”

Tracing the origin and development of the term “dyspareunia” will provide a useful background for
discussing contemporary usage and classification issues. Barnes (1874) coined the term “dyspareunia” (difficult or painful mating) in an attempt to encompass a variety of painful conditions interfering with intercourse. He justified the creation of this term by analogy to other nineteenth century terms like “dyspepsia” or “dysmenorrhea.” Although Barnes (1874, Ch. 12) emphasized the importance of treating gynecological pain, his choice of the term dyspareunia emphasized the interference with function (intercourse) rather than the pain itself. Barnes’ etiological view was physiologically based and he stressed that dyspareunia had multiple causes: “In short, almost every disease to which the sexual organs are liable may entail dyspareunia for one of its consequences . . . ” (p. 69). This view would not be considered an unusual one in gynecology today.

A very different view of dyspareunia was being developed in the mental health domain. During the twentieth century, under the influence of psychoanalysis, the concept of psychogenic (hysterical) pain was proposed. This concept was also applied to pain occurring during sexual intercourse and treated accordingly (see Singer-Kaplan, 1983, p. 258). This was not a popular approach for many modern sexologists and some, including Masters and Johnson (1970), reverted to an organically based “Barnesian” approach. On the other hand, non-psychoanalytic but psychologically minded sexologists attributed dyspareunia to a variety of factors, ranging from childhood abuse to inadequate sexual technique. As a result, what we are left with today is a term based on interference with function (i.e., intercourse) that is typically used quite differently by organically based physicians and psychologically based mental health professionals.

My discussion of the definition and classification of dyspareunia will focus solely on women. While current nosologies recognize dyspareunia in both sexes, the male version appears to be relatively rare. Moreover, there is only a minuscule scientific and clinical literature relating to men (e.g., Luzzi, 2003; Wesselman, Brunett, Abramovici, & Heinberg, 1997). Despite identical labels, it is hard to know for the moment whether dyspareunia in men and women is the same phenomenon. I will also not discuss the relationship of dyspareunia to vaginismus. All major nosologies carefully differentiate dyspareunia from vaginismus. In view of recent data (Basson & Riley, 1994; de Kruijf, Ter Kuile, Weijenborg, & van Lankveld, 2000; Reissing, Binik, Khalifé, Cohen, & Amsel, 2003; van Lankveld, Brewaeys, Ter Kuile, & Weijenborg, 1995), this differentiation appears highly questionable; unfortunately, an adequate discussion is beyond the scope this paper. Finally, I will not enter into the discussion of the validity of the “organic/due to a medical condition/psychogenic/combined factors” differentiation of dyspareunia except to say that at our current level of knowledge, there are not even any formal suggestions, let alone validated criteria, to make this distinction. In practice, psychogenic dyspareunia is a diagnosis typically made when relevant organic factors are excluded. Unfortunately, the definition of a “relevant organic factor” usually depends more on the opinions and patience of the clinician and patient rather than any formal criteria or data.3

THEORETICAL ISSUES RELATING TO THE CLASSIFICATION OF DYSPAREUNIA

Evolution of the Classification of Dyspareunia in the Diagnostic and Statistical Manual of the American Psychiatric Association

Although the DSM-II appears to have considered dyspareunia as a “psychosomatic disorder” (American Psychiatric Association, 1968), this classification was changed in the DSM-III (American Psychiatric Association, 1980) when the category of sexual dysfunction was introduced. In the DSM-III-R (American Psychiatric Association, 1987), dyspareunia continued to be classified as a sexual dysfunction and was grouped with vaginismus under the new term of “sexual pain disorder.” Although dyspareunia is also mentioned in DSM-III and DSM-III-R, as a possible symptom contributing to somatization disorder, it is not explicitly mentioned elsewhere. The DSM-IV (American Psychiatric Association, 1994) and DSM-IV-TR continue to mention dyspareunia as a possible symptom of somatization but clearly consider it a sexual dysfunction.

The rationale behind this classification history is not at all clear. The DSM-III introduced the concept of sexual dysfunction and defined it with reference to the sexual response cycle. Specific disturbances of desire, excitement, and orgasm became the main categories of sexual dysfunction (e.g., premature or early ejaculation, inhibited female orgasm or female orgasmic disorder, etc.). Although dyspareunia is not linked to, and does not interfere specifically with, any stage of the sexual

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3The ICD-10 also divides dyspareunia into organic and psychogenic categories without giving criteria on how to accomplish this. Psychogenic dyspareunia is classified as a sexual dysfunction while organic dyspareunia is classified under the heading of “Pain and other conditions associated with female genital organs and menstrual cycle.” The ICD-10 does not have a specific pain disorder category and in general classifies pain by anatomic location and by organic/psychogenic etiology.