Sexual and Gender Identity Disorders

This section contains the Sexual Dysfunctions, the Paraphilias, and the Gender Identity Disorders. The **Sexual Dysfunctions** are characterized by disturbance in sexual desire and in the psychophysiological changes that characterize the sexual response cycle and cause marked distress and interpersonal difficulty. The Sexual Dysfunctions include Sexual Desire Disorders (i.e., Hypoactive Sexual Desire Disorder, Sexual Aversion Disorder), Sexual Arousal Disorders (i.e., Female Sexual Arousal Disorder, Male Erectile Disorder), Orgasmic Disorders (i.e., Female Orgasmic Disorder, Male Orgasmic Disorder, Premature Ejaculation), Sexual Pain Disorders (i.e., Dyspareunia, Vaginismus), Sexual Dysfunction Due to a General Medical Condition, Substance-Induced Sexual Dysfunction, and Sexual Dysfunction Not Otherwise Specified.

The **Paraphilias** are characterized by recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Paraphilias include Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Transvestic Fetishism, Voyeurism, and Paraphilia Not Otherwise Specified.

Gender Identity Disorders are characterized by strong and persistent cross-gender identification accompanied by persistent discomfort with one's assigned sex. *Gender identity* refers to an individual's self-perception as male or female. The term *gender dysphoria* denotes strong and persistent feelings of discomfort with one's assigned sex, the desire to possess the body of the other sex, and the desire to be regarded by others as a member of the other sex. The terms gender identity and gender dysphoria should be distinguished from the term *sexual orientation,* which refers to erotic attraction to males, females, or both.

Sexual Disorder Not Otherwise Specified is included for coding disorders of sexual functioning that are not classifiable in any of the specific categories. It is important to note that notions of deviance, standards of sexual performance, and concepts of appropriate gender role can vary from culture to culture.

Sexual Dysfunctions

A Sexual Dysfunction is characterized by a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse. The sexual response cycle can be divided into the following phases:

1. *Desire:* This phase consists of fantasies about sexual activity and the desire to have sexual activity.
2. *Excitement:* This phase consists of a subjective sense of sexual pleasure and accompanying physiological changes. The major changes in the male consist of penile tumescence and erection. The major changes in the female consist of vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitalia.
3. *Orgasm:* This phase consists of a peaking of sexual pleasure, with release of sexual tension and rhythmic contraction of the perineal muscles and reproductive organs. In the male, there is the sensation of ejaculatory inevitability, which is followed by ejaculation of semen. In the female, there are contractions (not always subjectively experienced as such) of the wall of the outer third of the vagina. In both genders, the anal sphincter rhythmically contracts.
4. *Resolution:* This phase consists of a sense of muscular relaxation and general well-being. During this phase, males are physiologically refractory to further erection and orgasm for a variable period of time. In contrast, females may be able to respond to additional stimulation almost immediately.

Disorders of sexual response may occur at one or more of these phases. Whenever more than one Sexual Dysfunction is present, all are recorded. No attempt is made in the criteria sets to specify a minimum frequency or range of settings, activities, or types of sexual encounters in which the dysfunction must occur. This judgment must be made by the clinician, taking into account such factors as the age and experience of the individual, frequency and chronicity of the symptom, subjective distress, and effect on

other areas of functioning. The words "persistent or recurrent" in the diagnostic criteria indicate the need for such a clinical judgment. If sexual stimulation is inadequate in either focus, intensity, or duration, the diagnosis of Sexual Dysfunction involving excitement or orgasm is not made.

Subtypes

Subtypes are provided to indicate the onset, context, and etiological factors associated with the Sexual Dysfunctions. If multiple Sexual Dysfunctions are present, the appropriate subtypes for each may be noted. These subtypes do not apply to a diagnosis of Sexual Dysfunction Due to a General Medical Condition or Substance-Induced Sexual Dysfunction.

One of the following subtypes may be used to indicate the nature of the onset of the Sexual Dysfunction:

Lifelong Type. This subtype applies if the sexual dysfunction has been present since the onset of sexual functioning.
Acquired Type. This subtype applies if the sexual dysfunction develops only after a period of normal functioning.

One of the following subtypes may be used to indicate the context in which the Sexual Dysfunction occurs:

Generalized Type. This subtype applies if the sexual dysfunction is not limited to certain types of stimulation, situations, or partners.
Situational Type. This subtype applies if the sexual dysfunction is limited to certain types of stimulation, situations, or partners. The specific situational pattern of the dysfunction may aid in the differential diagnosis. For example, normal masturbatory function in the presence of impaired partner relational functioning would suggest that a chief complaint of erectile dysfunction is more likely due to an interpersonal or intrapsychic problem rather than attributable to a general medical condition or a substance.

One of the following subtypes may be used to indicate etiological factors associated with the Sexual Dysfunction:

Due to Psychological Factors. This subtype applies when psychological

factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the Sexual Dysfunction, and general medical conditions and substances play no role in the etiology of the Sexual Dysfunction.

Due to Combined Factors. This subtype applies when 1) psychological factors are judged to have a role in the onset, severity, exacerbation, or maintenance of the Sexual Dysfunction; and 2) a general medical condition or substance use is also judged to be contributory but is not sufficient to account for the Sexual Dysfunction. If a general medical condition or substance use (including medication side effects) is sufficient to account for the Sexual Dysfunction, Sexual Dysfunction Due to a General Medical Condition (See linked section) and/or Substance-Induced Sexual Dysfunction (See linked section) is diagnosed.

Associated Disorders

Sexual dysfunction may be associated with Mood Disorders and Anxiety Disorders (Obsessive-Compulsive Disorder, Panic Disorder With Agoraphobia, and Specific Phobia).

Specific Culture, Age, and Gender Features

Clinical judgments about the presence of a Sexual Dysfunction should take into account the individual's ethnic, cultural, religious, and social background, which may influence sexual desire, expectations, and attitudes about performance. For example, in some societies, sexual desires on the part of the female are given less relevance (especially when fertility is the primary concern). Aging may be associated with a lowering of sexual interest and functioning (especially in males), but there are wide individual differences in age effects.

Prevalence

There are few systematic epidemiological data regarding the prevalence of the various sexual dysfunctions, and these show extremely wide variability, probably reflecting differences in assessment methods, definitions used, and characteristics of sampled populations. The most comprehensive survey to date, conducted on a representative

sample of the U.S. population between ages 18 and 59, suggests the following prevalence estimates for various sexual complaints: 3% for male dyspareunia, 15% for female dyspareunia, 10% for male orgasm problems, 25% for female orgasm problems, 33% for female hypoactive sexual desire, 27% for premature ejaculation, 20% for female arousal problems, and 10% for male erectile difficulties. Male erectile problems also increase in prevalence after age 50. It is unclear whether these sexual complaints would have met diagnostic criteria for a DSM-IV Sexual Disorder. Estimates of prevalence rates for sexual aversion, vaginismus, sexual dysfunctions due to a general medical condition, and substance-induced sexual dysfunctions are not available.

Differential Diagnosis

If the Sexual Dysfunction is judged to be caused exclusively by the physiological effects of a specified general medical condition, the diagnosis is **Sexual Dysfunction Due to a General Medical Condition** (See linked section). This determination is based on history, laboratory findings, or physical examination. If the Sexual Dysfunction is judged to be caused exclusively by the physiological effects of a drug of abuse, a medication, or toxin exposure, the diagnosis is **Substance-Induced Sexual Dysfunction** (See linked section). The clinician should inquire carefully about the nature and extent of substance use, including medications. Symptoms that occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or after medication use may be especially indicative of a Substance-Induced Sexual Dysfunction, depending on the type or amount of the substance used or the duration of use.

If the clinician has ascertained that the sexual dysfunction is due to both a general medical condition and substance use, both diagnoses (i.e., Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction) can be given. A primary Sexual Dysfunction diagnosis with the subtype **Due to Combined Factors** is made if a combination of psychological factors and either a general medical condition or a substance is judged to have an etiological role, but no one etiology is sufficient to account for the dysfunction. If the clinician cannot determine the etiological roles of psychological factors, a general medical condition, and substance use, **Sexual Dysfunction Not Otherwise Specified** is diagnosed.

The diagnosis of a Sexual Dysfunction is also not made if the dysfunction is better accounted for by another Axis I disorder (e.g., if diminished sexual desire occurs only in the context of a Major Depressive Episode). However, if the disturbance in sexual functioning antedates the Axis I disorder or is a focus of independent clinical attention,

an additional diagnosis of Sexual Dysfunction can also be made. Commonly, if one Sexual Dysfunction is present (e.g., a Sexual Arousal Disorder), additional Sexual Dysfunctions will also be present (e.g., Hypoactive Sexual Desire Disorder). In such cases, all should be diagnosed. A **Personality Disorder** may coexist with a Sexual Dysfunction. In such cases, the Sexual Dysfunction should be recorded on Axis I and the Personality Disorder should be recorded on Axis II. If another clinical condition, such as a **Relational Problem,** is associated with the disturbance in sexual functioning, the Sexual Dysfunction should be diagnosed and the other clinical condition is also noted on Axis I. Occasional problems with sexual desire, arousal, or orgasm that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Sexual Dysfunctions.

Sexual Desire Disorders

302.71 Hypoactive Sexual Desire Disorder

Diagnostic Features

The essential feature of Hypoactive Sexual Desire Disorder is a deficiency or absence of sexual fantasies and desire for sexual activity (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction 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 (including medications) or a general medical condition (Criterion C). Low sexual desire may be global and encompass all forms of sexual expression or may be situational and limited to one partner or to a specific sexual activity (e.g., intercourse but not masturbation). There is little motivation to seek stimuli and diminished frustration when deprived of the opportunity for sexual expression. The individual usually does not initiate sexual activity or may only engage in it reluctantly when it is initiated by the partner. Although the frequency of sexual experiences is usually low, pressure from the partner or nonsexual needs (e.g., for physical comfort or intimacy) may increase the frequency of sexual encounters. Because of a lack of normative age- or gender-related data on frequency or

degree of sexual desire, the diagnosis must rely on clinical judgment based on the individual's characteristics, the interpersonal determinants, the life context, and the cultural setting. The clinician may need to assess both partners when discrepancies in sexual desire prompt the call for professional attention. Apparent "low desire" in one partner may instead reflect an excessive need for sexual expression by the other partner. Alternatively, both partners may have levels of desire within the normal range but at different ends of the continuum.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Hypoactive Sexual Desire Disorder. (See descriptions on See linked section.)

Associated Features and Disorders

Low sexual interest is frequently associated with problems of sexual arousal or with orgasm difficulties. The deficiency in sexual desire may be the primary dysfunction or may be the consequence of emotional distress induced by disturbances in excitement or orgasm. However, some individuals with low sexual desire retain the capacity for adequate sexual excitement and orgasm in response to sexual stimulation. General medical conditions may have a nonspecific deleterious effect on sexual desire due to weakness, pain, problems with body image, or concerns about survival. Depressive disorders are often associated with low sexual desire, and the onset of depression may precede, co-occur with, or be the consequence of the deficient sexual desire. Individuals with Hypoactive Sexual Desire Disorder may have difficulties developing stable sexual relationships and may have marital dissatisfaction and disruption.

Course

The age at onset for individuals with Lifelong forms of Hypoactive Sexual Desire Disorder is puberty. More frequently, the disorder develops in adulthood, after a period of adequate sexual interest, in association with psychological distress, stressful life events, or interpersonal difficulties. The loss of sexual desire may be continuous or episodic,

depending on psychosocial or relationship factors. An episodic pattern of loss of sexual desire occurs in some individuals in relation to problems with intimacy and commitment.

Differential Diagnosis

Hypoactive Sexual Desire Disorder must be distinguished from **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (See linked section). This determination is based on history, laboratory findings, or physical examination. Certain general medical conditions such as neurological, hormonal, and metabolic abnormalities may specifically impair the physiological substrates of sexual desire. Abnormalities in total and bioavailable testosterone and prolactin may indicate hormonal disorders responsible for loss of sexual desire. If both Hypoactive Sexual Desire Disorder and a general medical condition are present, but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Hypoactive Sexual Desire Disorder, Due to Combined Factors, is diagnosed.

In contrast to Hypoactive Sexual Desire Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., antihypertensive medication, a drug of abuse) (See linked section). If both Hypoactive Sexual Desire Disorder and substance use are present, but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Hypoactive Sexual Desire Disorder, Due to Combined Factors, is diagnosed. If the low sexual desire is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Hypoactive Sexual Desire Disorder may also occur in association with other Sexual Dysfunctions (e.g., Male Erectile Dysfunction). If so, both should be noted. An additional diagnosis of Hypoactive Sexual Desire Disorder is usually not made if the low sexual desire is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder). The additional diagnosis may be appropriate when the low desire predates the Axis I disorder or is a focus of independent clinical attention. **Occasional problems with sexual desire** that are not persistent or recurrent or are not accompanied by marked distress or

interpersonal difficulty are not considered to be Hypoactive Sexual Desire Disorder.

Diagnostic Criteria for 302.71 Hypoactive Sexual Desire Disorder

A. Persistently or recurrently deficient (or absent) sexual fantasies and desire for sexual activity. The judgment of deficiency or absence is made by the clinician, taking into account factors that affect sexual functioning, such as age and the context of the person's life.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction 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.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

302.79 Sexual Aversion Disorder

Diagnostic Features

The essential feature of Sexual Aversion Disorder is the aversion to and active avoidance of genital sexual contact with a sexual partner (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction) (Criterion C). The individual reports anxiety, fear, or disgust when confronted by a sexual opportunity with a partner. The aversion to genital contact may be focused on a particular aspect of sexual experience (e.g., genital secretions, vaginal penetration). Some individuals experience generalized revulsion to all sexual stimuli, including kissing and touching. The intensity of the individual's reaction when exposed to the aversive stimulus may range from moderate anxiety and lack of pleasure to extreme psychological distress.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Sexual Aversion Disorder. (See descriptions on See linked section.)

Associated Features and Disorders

When confronted with a sexual situation, some individuals with severe Sexual Aversion Disorder may experience Panic Attacks with extreme anxiety, feelings of terror, faintness, nausea, palpitations, dizziness, and breathing difficulties. There may be markedly impaired interpersonal relations (e.g., marital dissatisfaction). Individuals may avoid sexual situations or potential sexual partners by covert strategies (e.g., going to

sleep early, traveling, neglecting personal appearance, using substances, and being overinvolved in work, social, or family activities).

Differential Diagnosis

Sexual Aversion Disorder may also occur in association with other Sexual Dysfunctions (e.g., Dyspareunia). If so, both should be noted. An additional diagnosis of Sexual Aversion Disorder is usually not made if the sexual aversion is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder). The additional diagnosis may be made when the aversion predates the Axis I disorder or is a focus of independent clinical attention. Although sexual aversion may technically meet the criteria for **Specific Phobia,** this additional diagnosis is not given. **Occasional sexual aversion** that is not persistent or recurrent or is not accompanied by marked distress or interpersonal difficulty is not considered to be a Sexual Aversion Disorder.

Diagnostic Criteria for 302.79 Sexual Aversion Disorder

A. Persistent or recurrent extreme aversion to, and avoidance of, all (or almost all) genital sexual contact with a sexual partner.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction is not better accounted for by another Axis I disorder (except another Sexual Dysfunction).

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Situational Type

Generalized Type

Specify:

Due to Psychological Factors

Due to Combined Factors

Sexual Arousal Disorders

302.72 Female Sexual Arousal Disorder

Diagnostic Features

The essential feature of Female Sexual Arousal Disorder is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement (Criterion A). The arousal response consists of vasocongestion in the pelvis, vaginal lubrication and expansion, and swelling of the external genitalia. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction 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 (including medications) or a general medical condition (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Female Sexual Arousal Disorder. (See descriptions on See linked section.)

Associated Features and Disorders

Limited evidence suggests that Female Sexual Arousal Disorder is often accompanied by Sexual Desire Disorders and Female Orgasmic Disorder. The individual with Female

Sexual Arousal Disorder may have little or no subjective sense of sexual arousal. The disorder may result in painful intercourse, sexual avoidance, and the disturbance of marital or sexual relationships.

Differential Diagnosis

Female Sexual Arousal Disorder must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., menopausal or postmenopausal reductions in estrogen levels, atrophic vaginitis, diabetes mellitus, radiotherapy of the pelvis) (See linked section). Reduced lubrication has also been reported in association with lactation. This determination is based on history, laboratory findings, or physical examination. If both Female Sexual Arousal Disorder and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological consequences of the general medical condition, then Female Sexual Arousal Disorder, Due to Combined Factors, is diagnosed.

In contrast to Female Sexual Arousal Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., reduced lubrication caused by antihypertensives or antihistamines) (See linked section). If both Female Sexual Arousal Disorder and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Female Sexual Arousal Disorder, Due to Combined Factors, is diagnosed.

If the arousal problems are judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Female Sexual Arousal Disorder may also occur in association with other Sexual Dysfunctions (e.g., Female Orgasmic Disorder). If so, both should be noted. An additional diagnosis of Female Sexual Arousal Disorder is usually not made if the sexual arousal problem is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder). The additional diagnosis may be made when the problem with sexual arousal predates the Axis I disorder or is a focus of independent clinical attention. **Occasional problems**

with sexual arousal that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Female Sexual Arousal Disorder. A diagnosis of Female Sexual Arousal Disorder is also not appropriate if the problems in arousal are due to sexual stimulation that is not adequate in focus, intensity, and duration.

Diagnostic Criteria for 302.72 Female Sexual Arousal Disorder

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The sexual dysfunction 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.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

302.72 Male Erectile Disorder

Diagnostic Features

The essential feature of Male Erectile Disorder is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction 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 (including medications) or a general medical condition (Criterion C).

There are different patterns of erectile dysfunction. Some individuals will report the inability to obtain any erection from the outset of a sexual experience. Others will complain of first experiencing an adequate erection and then losing tumescence when attempting penetration. Still others will report that they have an erection that is sufficiently firm for penetration but that they then lose tumescence before or during thrusting. Some males may report being able to experience an erection only during self-masturbation or on awakening. Masturbatory erections may be lost as well, but this is not common.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Male Erectile Disorder. (See descriptions on See linked section.)

Associated Features and Disorders

The erectile difficulties in Male Erectile Disorder are frequently associated with sexual anxiety, fear of failure, concerns about sexual performance, and a decreased subjective sense of sexual excitement and pleasure. Erectile dysfunction can disrupt existing marital or sexual relationships and may be the cause of unconsummated marriages and infertility. This disorder may be associated with Hypoactive Sexual Desire Disorder and Premature Ejaculation. Individuals with Mood Disorders and Substance-Related Disorders often report problems with sexual arousal.

Course

The various forms of Male Erectile Disorder follow different courses, and the age at onset varies substantially. The few individuals who have never been able to experience an erection of sufficient quality to complete sexual activity with a partner typically have a chronic, lifelong disorder. Acquired cases may remit spontaneously 15%–30% of the time. Situational cases may be dependent on a type of partner or the intensity or quality of the relationship and are episodic and frequently recurrent.

Differential Diagnosis

Male Erectile Disorder must be distinguished from **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., diabetes mellitus, multiple sclerosis, renal failure, peripheral neuropathy, peripheral vascular disease, spinal cord injury, injury of the autonomic nervous system by surgery or radiation) (See linked section). This determination is based on history (e.g., impaired erectile functioning during masturbation), laboratory findings, or physical examination. Nocturnal penile tumescence studies can demonstrate whether erections occur during sleep and may be helpful in differentiating primary erectile disorders from Male Erectile Disorder Due to a General Medical Condition. Penile blood pressure, pulse-wave assessments, or duplex ultrasound studies can indicate vasculogenic loss of erectile functioning. Invasive procedures such as intracorporeal pharmacological testing or angiography can assess the presence of arterial flow problems. Cavernosography can evaluate venous competence. If both Male Erectile Disorder and a general medical condition are present but it is judged that the erectile dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Male Erectile Disorder, Due to Combined Factors, is diagnosed.

A **Substance-Induced Sexual Dysfunction** is distinguished from Male Erectile Disorder by the fact that the sexual dysfunction is judged to be due exclusively to the direct physiological effects of a substance (e.g., antihypertensive medication, antidepressant medication, neuroleptic medication, a drug of abuse) (See linked section). If both Male Erectile Disorder and substance use are present but it is judged that the erectile dysfunction is not due exclusively to the direct physiological effects of the substance use, then Male Erectile Disorder, Due to Combined Factors, is diagnosed.

If the arousal problems are judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Male Erectile Disorder may also occur in association with other Sexual Dysfunctions (e.g., Premature Ejaculation). If so, both should be noted. An additional diagnosis of Male Erectile Disorder is usually not made if the erectile dysfunction is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder, Obsessive-Compulsive Disorder). The additional diagnosis may be made when the erectile dysfunction predates the Axis I disorder or is a focus of independent clinical attention. **Occasional problems with having erections** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Male Erectile Disorder. A diagnosis of Male Erectile Disorder is also not appropriate if the erectile dysfunction is due to sexual stimulation that is not adequate in focus, intensity, and duration. Older males may require more stimulation or take longer to achieve a full erection. These physiological changes should not be considered to be Male Erectile Disorder.

Diagnostic Criteria for 302.72 Male Erectile Disorder

A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The erectile dysfunction is not better accounted for by another Axis I disorder (other than a 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.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

Orgasmic Disorders

302.73 Female Orgasmic Disorder (*formerly* Inhibited Female Orgasm)

Diagnostic Features

The essential feature of Female Orgasmic Disorder is a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase (Criterion A). Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The dysfunction 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 (including medications) or a general medical condition (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Female Orgasmic Disorder. (See descriptions on See linked section.)

Associated Features and Disorders

No association has been found between specific patterns of personality traits or psychopathology and orgasmic dysfunction in females. Female Orgasmic Disorder may affect body image, self-esteem, or relationship satisfaction. According to controlled studies, orgasmic capacity is not correlated with vaginal size or pelvic muscle strength. Although females with spinal cord lesions, removal of the vulva, or vaginal excision and reconstruction have reported reaching orgasm, orgasmic dysfunction is commonly reported in women with these conditions. In general, however, chronic general medical conditions like diabetes or pelvic cancer are more likely to impair the arousal phase of the sexual response, leaving orgasmic capacity relatively intact.

Course

Because orgasmic capacity in females may increase with increasing sexual experience, Female Orgasmic Disorder may be more prevalent in younger women. Most female orgasmic disorders are lifelong rather than acquired. Once a female learns how to reach orgasm, it is uncommon for her to lose that capacity, unless poor sexual communication, relationship conflict, a traumatic experience (e.g., rape), a Mood Disorder, or a general medical condition intervenes. When orgasmic dysfunction occurs only in certain situations, difficulty with sexual desire and arousal are often present in addition to the orgasmic disorder. Many females increase their orgasmic capacity as they experience a wider variety of stimulation and acquire more knowledge about their own bodies.

Differential Diagnosis

Female Orgasmic Disorder must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., spinal cord lesion) (See linked section). This determination is based on history, laboratory findings, or physical examination. If both Female Orgasmic Disorder and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Female Orgasmic Disorder, Due to Combined Factors, is diagnosed.

In contrast to Female Orgasmic Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a

substance (e.g., antidepressants, benzodiazepines, neuroleptics, antihypertensives, opioids) (See linked section). If both Female Orgasmic Disorder and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Female Orgasmic Disorder, Due to Combined Factors, is diagnosed.

If the sexual dysfunction is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Female Orgasmic Disorder may also occur in association with other Sexual Dysfunctions (e.g., Female Sexual Arousal Disorder). If so, both should be noted. An additional diagnosis of Female Orgasmic Disorder is usually not made if the orgasmic difficulty is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder). This additional diagnosis may be made when the orgasmic difficulty predates the Axis I disorder or is a focus of independent clinical attention. **Occasional orgasmic problems** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Female Orgasmic Disorder. A diagnosis of Female Orgasmic Disorder is also not appropriate if the problems are due to sexual stimulation that is not adequate in focus, intensity, and duration.

Diagnostic Criteria for 302.73 Female Orgasmic Disorder

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Women exhibit wide variability in the type or intensity of stimulation that triggers orgasm. The diagnosis of Female Orgasmic Disorder should be based on the clinician's judgment that the woman's orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The orgasmic dysfunction 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.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

302.74 Male Orgasmic Disorder (*formerly* Inhibited Male Orgasm)

Diagnostic Features

The essential feature of Male Orgasmic Disorder is a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. In judging whether the orgasm is delayed, the clinician should take into account the person's age and whether the stimulation is adequate in focus, intensity, and duration (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The orgasmic dysfunction 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 (including medications) or a general medical condition (Criterion C). In the most common form of Male Orgasmic Disorder, a male cannot reach orgasm during intercourse, although he can ejaculate from a partner's manual or oral stimulation. Some males with Male Orgasmic Disorder can reach coital orgasm but only after very prolonged and intense noncoital stimulation. Some can ejaculate only from masturbation. An even smaller subgroup have experienced orgasm only at the moment of waking from an erotic dream.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Male Orgasmic Disorder. (See descriptions on See linked section.)

Associated Features and Disorders

Many coitally inorgasmic males describe feeling aroused at the beginning of a sexual encounter but that thrusting gradually becomes a chore rather than a pleasure. A pattern of paraphilic sexual arousal may be present. When a man has hidden his lack of coital orgasms from his wife, the couple may present with infertility of unknown cause. The disorder may result in the disturbance of existing marital or sexual relationships. Males can usually reach orgasm even when vascular or neurological conditions interfere with erectile rigidity. Both the sensation of orgasm and striated muscle contractions at orgasm remain intact in males who lose their prostate and seminal vesicles with radical pelvic cancer surgery. Orgasm also can occur in the absence of emission of semen (e.g., when sympathetic ganglia are damaged by surgery or autonomic neuropathy).

Differential Diagnosis

Male Orgasmic Disorder must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition.** The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., hyperprolactinemia) (See linked section). This determination is based on history, laboratory findings, or physical examination. Sensory threshold testing may demonstrate reduced sensation in the skin on the penis that is due to a neurological condition (e.g., spinal cord injuries, sensory neuropathies). If both Male Orgasmic Disorder and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then Male Orgasmic Disorder, Due to Combined Factors, is diagnosed.

In contrast to Male Orgasmic Disorder, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (e.g., alcohol, opioids, antihypertensives, antidepressants, neuroleptics) (See linked section). If both Male Orgasmic Disorder and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Male Orgasmic Disorder, Due to Combined Factors, is diagnosed.

If the orgasmic dysfunction is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Male Orgasmic Disorder may also occur in association with other Sexual Dysfunctions (e.g., Male Erectile Disorder). If so, both should be noted. An additional

diagnosis of Male Orgasmic Disorder is usually not made if the orgasmic difficulty is better accounted for by **another Axis I disorder** (e.g., Major Depressive Disorder). An additional diagnosis may be made when the orgasmic difficulty predates the Axis I disorder or is a focus of independent clinical attention. Several types of Sexual Dysfunction (e.g., ejaculation but without pleasurable orgasm, orgasm that occurs without ejaculation of semen or with seepage of semen rather than propulsive ejaculation) would be diagnosed as **Sexual Dysfunction Not Otherwise Specified** rather than as Male Orgasmic Disorder.

Occasional orgasmic problems that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty are not considered to be Male Orgasmic Disorder. As males age, they may require a longer period of stimulation to achieve orgasm. The clinician must also ascertain that there has been sufficient stimulation to attain orgasm.

Diagnostic Criteria for 302.74 Male Orgasmic Disorder

A. Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The orgasmic dysfunction 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.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

302.75 Premature Ejaculation

Diagnostic Features

The essential feature of Premature Ejaculation is the persistent or recurrent onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it (Criterion A). The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity. The majority of males with this disorder can delay orgasm during self-masturbation for a considerably longer time than during coitus. Partners' estimates of the duration of time from the beginning of sexual activity until ejaculation as well as their judgment of whether Premature Ejaculation is a problem can be quite disparate. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids) (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Premature Ejaculation. (See descriptions on See linked section.)

Associated Features and Disorders

Like other Sexual Dysfunctions, Premature Ejaculation may create tension in a relationship. Some unmarried males hesitate to begin dating new partners out of fear of embarrassment from the disorder. This can contribute to social isolation.

Course

A majority of young males learn to delay orgasm with sexual experience and aging, but some continue to ejaculate prematurely and may seek help for the disorder. Some males are able to delay ejaculation in a long-term relationship but experience a recurrence of Premature Ejaculation when they have a new partner. Typically, Premature Ejaculation is seen in young men and is present from their first attempts at intercourse. However, some males lose the ability to delay orgasm after a period of adequate function. When onset occurs after a period of adequate sexual function, the context is often a decreased frequency of sexual activity, intense performance anxiety with a new partner, or loss of ejaculatory control related to difficulty achieving or maintaining erections. Some males who have stopped regular use of alcohol may develop Premature Ejaculation because they relied on their drinking to delay orgasm instead of learning behavioral strategies.

Differential Diagnosis

Premature Ejaculation should be distinguished from **erectile dysfunction related to the development of a general medical condition** (See linked section). Some individuals with erectile dysfunction may omit their usual strategies for delaying orgasm. Others require prolonged noncoital stimulation to develop a degree of erection sufficient for intromission. In such individuals, sexual arousal may be so high that ejaculation occurs immediately. **Occasional problems with premature ejaculation** that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty do not qualify for the diagnosis of Premature Ejaculation. The clinician should also take into account the individual's age, overall sexual experience, recent sexual activity, and the novelty of the partner. When problems with Premature Ejaculation are due exclusively to substance use (e.g., Opioid Withdrawal), a **Substance-Induced Sexual Dysfunction** can be diagnosed (See linked section).

Diagnostic Criteria for 302.75 Premature Ejaculation

A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).

Specify **type:**

Lifelong Type

Acquired Type

Specify **type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

Sexual Pain Disorders

302.76 Dyspareunia (Not Due to a General Medical Condition)

Diagnostic Features

The essential feature of Dyspareunia is genital pain that is associated with sexual intercourse (Criterion A). Although it is most commonly experienced during coitus, it may also occur before or after intercourse. The disorder can occur in both males and females. In females, the pain may be described as superficial during intromission or as deep during penile thrusting. The intensity of the symptoms may range from mild discomfort to sharp pain. The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except for 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 (Criterion C).

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Dyspareunia. (See descriptions on See linked section.)

Associated Features and Disorders

Dyspareunia is rarely a chief complaint in mental health settings. Individuals with Dyspareunia typically seek treatment in general medical settings. The physical examination for individuals with this disorder typically does not demonstrate genital abnormalities. The repeated experience of genital pain during coitus may result in the avoidance of sexual experience, disrupting existing sexual relationships or limiting the development of new sexual relationships.

Course

The limited amount of information available suggests that the course of Dyspareunia tends to be chronic.

Differential Diagnosis

Dyspareunia must be distinguished from **Sexual Dysfunction Due to a General Medical Condition** (See linked section). The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., insufficient vaginal lubrication; pelvic pathology such as vaginal or urinary tract infections, vaginal scar tissue, endometriosis, or adhesions; postmenopausal vaginal atrophy; temporary estrogen deprivation during lactation; urinary tract irritation or infection; or gastrointestinal conditions). This determination is based on history, laboratory findings, or physical examination. If both Dyspareunia and a general medical condition are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the general medical condition, then a diagnosis of Dyspareunia, Due to Combined Factors, is made.

In contrast to Dyspareunia, a **Substance-Induced Sexual Dysfunction** is judged to be due exclusively to the direct physiological effects of a substance (See linked section). Painful orgasm has been reported with fluphenazine, thioridazine, and amoxapine. If both Dyspareunia and substance use are present but it is judged that the sexual dysfunction is not due exclusively to the direct physiological effects of the substance use, then Dyspareunia, Due to Combined Factors, is diagnosed.

If the sexual pain is judged to be due exclusively to the physiological effects of both a general medical condition and substance use, both Sexual Dysfunction Due to a General

Medical Condition and Substance-Induced Sexual Dysfunction are diagnosed.

Dyspareunia is not diagnosed if it is caused exclusively by Vaginismus or a lack of lubrication. An additional diagnosis of Dyspareunia is usually not made if the sexual dysfunction is better accounted for by **another Axis I disorder** (e.g., Somatization Disorder). The additional diagnosis may be made when the orgasmic difficulty predates the Axis I disorder or is a focus of independent clinical attention. Dyspareunia can also occur in association with other Sexual Dysfunctions (except Vaginismus), and if criteria for both are met, both should be coded. **Occasional pain associated with sexual intercourse** that is not persistent or recurrent or is not accompanied by marked distress or interpersonal difficulty is not considered to be Dyspareunia.

Diagnostic Criteria for 302.76 Dyspareunia

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.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

306.51 Vaginismus (Not Due to a General Medical Condition)

Diagnostic Features

The essential feature of Vaginismus is the recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted (Criterion A). The disturbance must cause marked distress or interpersonal difficulty (Criterion B). The disturbance 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 general medical condition (Criterion C). In some females, even the anticipation of vaginal insertion may result in muscle spasm. The contraction may range from mild, inducing some tightness and discomfort, to severe, preventing penetration.

Subtypes

Subtypes are provided to indicate onset (**Lifelong** versus **Acquired**), context (**Generalized** versus **Situational**), and etiological factors (**Due to Psychological Factors, Due to Combined Factors**) for Vaginismus. (See descriptions on See linked section.)

Associated Features and Disorders

Sexual responses (e.g., desire, pleasure, orgasmic capacity) may not be impaired unless penetration is attempted or anticipated. The physical obstruction due to muscle contraction usually prevents coitus. The condition, therefore, can limit the development of sexual relationships and disrupt existing relationships. Cases of unconsummated marriages and infertility have been found to be associated with this condition. The

diagnosis is often made during routine gynecological examinations when response to the pelvic examination results in the readily observed contraction of the vaginal outlet. In some cases, the intensity of the contraction may be so severe or prolonged as to cause pain. However, Vaginismus occurs in some women during sexual activity but not during a gynecological examination. The disorder is more often found in younger than in older females, in females with negative attitudes toward sex, and in females who have a history of being sexually abused or traumatized.

Course

Lifelong Vaginismus usually has an abrupt onset, first manifest during initial attempts at sexual penetration by a partner or during the first gynecological examination. Once the disorder is established, the course is usually chronic unless ameliorated by treatment. Acquired Vaginismus also may occur suddenly in response to a sexual trauma or a general medical condition.

Differential Diagnosis

Vaginismus must be distinguished from a **Sexual Dysfunction Due to a General Medical Condition** (See linked section). The appropriate diagnosis would be Sexual Dysfunction Due to a General Medical Condition when the dysfunction is judged to be due exclusively to the physiological effects of a specified general medical condition (e.g., endometriosis or vaginal infection). This determination is based on history, laboratory findings, or physical examination. Vaginismus may remain as a residual problem after resolution of the general medical condition. If both Vaginismus and a general medical condition are present but it is judged that the vaginal spasms are not due exclusively to the direct physiological effects of the general medical condition, a diagnosis of Vaginismus, Due to Combined Factors, is made.

Vaginismus may also occur in association with other Sexual Dysfunctions (e.g., Hypoactive Sexual Desire Disorder). If so, both should be noted. Although pain associated with sexual intercourse may occur with Vaginismus, an additional diagnosis of **Dyspareunia** is not given. An additional diagnosis of Vaginismus is usually not made if the vaginal spasms are better accounted for by **another Axis I condition** (e.g., Somatization Disorder). The additional diagnosis may be made when the vaginal spasms predate the Axis I disorder or are a focus of independent clinical attention.

Diagnostic Criteria for 306.51 Vaginismus

A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The disturbance is not better accounted for by another Axis I disorder (e.g., Somatization Disorder) and is not due exclusively to the direct physiological effects of a general medical condition.

***Specify* type:**

Lifelong Type

Acquired Type

***Specify* type:**

Generalized Type

Situational Type

Specify:

Due to Psychological Factors

Due to Combined Factors

Sexual Dysfunction Due to a General Medical Condition

Diagnostic Features

The essential feature of Sexual Dysfunction Due to a General Medical Condition is the presence of clinically significant sexual dysfunction that is judged to be due exclusively to the direct physiological effects of a general medical condition. The sexual dysfunction can involve pain associated with intercourse, hypoactive sexual desire, male erectile dysfunction, or other forms of sexual dysfunction (e.g., Orgasmic Disorders) and must cause marked distress or interpersonal difficulty (Criterion A). There must be evidence from the history, physical examination, or laboratory findings that the dysfunction is fully explained by the direct physiological effects of a general medical condition (Criterion B). The disturbance is not better accounted for by another mental disorder (e.g., Major Depressive Disorder) (Criterion C).

In determining whether the sexual dysfunction is exclusively due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the sexual dysfunction is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the sexual dysfunction and the general medical condition is etiological, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the sexual dysfunction. A second consideration is the presence of features that are atypical of a primary Sexual Dysfunction (e.g., atypical age at onset or course). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of the sexual dysfunction can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Sexual Dysfunction, a Substance-Induced Sexual Dysfunction, or another primary mental disorder (e.g., Major Depressive Disorder).

These determinations are explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (See linked section).

In contrast, a Sexual Dysfunction diagnosis with the subtype "Due to Combined Factors" is made if a combination of psychological factors and either a general medical condition or a substance is judged to have an etiological role, but no one etiology is sufficient to account for the dysfunction.

Subtypes

The diagnostic code and term for a Sexual Dysfunction Due to a General Medical Condition is selected based on the predominant Sexual Dysfunction. The terms listed below should be used instead of the overall rubric "Sexual Dysfunction Due to a General Medical Condition."

625.8 Female Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition].* This term is used if, in a female, deficient or absent sexual desire is the predominant feature.

608.89 Male Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition].* This term is used if, in a male, deficient or absent sexual desire is the predominant feature.

607.84 Male Erectile Disorder Due to . . . *[Indicate the General Medical Condition].* This term is used if male erectile dysfunction is the predominant feature.

625.0 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition].* This term is used if, in a female, pain associated with intercourse is the predominant feature.

608.89 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition].* This term is used if, in a male, pain associated with intercourse is the predominant feature.

625.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition].* This term is used if, in a female, some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates.

608.89 Other Male Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition].* This term is used if, in a male, some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates.

Recording Procedures

In recording the diagnosis of Sexual Dysfunction Due to a General Medical Condition, the clinician should note both the specific phenomenology of the dysfunction (from the list above) and the identified general medical condition judged to be causing the dysfunction on Axis I (e.g., 607.84 Male Erectile Disorder Due to Diabetes Mellitus). The ICD-9-CM code for the general medical condition is also noted on Axis III (e.g., 250.0 diabetes mellitus). (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

Associated General Medical Conditions

A variety of general medical conditions can cause sexual dysfunction, including neurological conditions (e.g., multiple sclerosis, spinal cord lesions, neuropathy, temporal lobe lesions), endocrine conditions (e.g., diabetes mellitus, hypothyroidism, hyper- and hypoadrenocorticism, hyperprolactinemia, hypogonadal states, pituitary dysfunction), vascular conditions, and genitourinary conditions (e.g., testicular disease, Peyronie's disease, urethral infections, postprostatectomy complications, genital injury or infection, atrophic vaginitis, infections of the vagina and external genitalia, postsurgical complications such as episiotomy scars, shortened vagina, cystitis, endometriosis, uterine prolapse, pelvic infections, neoplasms, oophorectomy without hormone replacement, and side effects of cancer treatments [surgical, radiation, chemotherapy]). Current clinical experience suggests that Sexual Dysfunction Due to a General Medical Condition is usually generalized. The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological general medical condition.

Differential Diagnosis

Sexual Dysfunction Due to a General Medical Condition is diagnosed only if the sexual dysfunction is fully explained by the direct effects of a general medical condition. If psychological factors also play a role in the onset, severity, exacerbation, or maintenance of a sexual dysfunction, the diagnosis is the **primary Sexual Dysfunction** (with the subtype **Due to Combined Factors**). In determining whether the sexual dysfunction is primary or exclusively due to the direct effects of a general medical condition, a comprehensive psychosexual and medical history is the most important

component of the evaluation. For males, tests such as nocturnal penile tumescence, vascular studies, and injection of tissue activators may be helpful in the assessment. Careful gynecological examination is important in making these determinations in women, especially in assessing Sexual Pain Disorders in females. Neurological evaluation and endocrine assessment may be helpful in both men and women.

If there is evidence of recent or prolonged substance use (including medications), withdrawal from a substance, or exposure to a toxin, and that the sexual dysfunction is fully explained by the direct effects of the substance, a **Substance-Induced Sexual Dysfunction** should be considered. The clinician should inquire carefully about the nature and extent of substance use, including medications. Symptoms that occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or after medication use may be especially indicative of a Substance-Induced Sexual Dysfunction, depending on the type or amount of the substance used or the duration of use. If the clinician has ascertained that the sexual dysfunction is due to both a general medical condition and substance use, both diagnoses (i.e., Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction) can be given.

Hypoactive sexual desire, arousal dysfunction, and, to a lesser extent, orgasmic dysfunction can also occur as symptoms of **Major Depressive Disorder.** In Major Depressive Disorder, no specific and direct causative pathophysiological mechanisms associated with a general medical condition can be demonstrated. Sexual Dysfunction Due to a General Medical Condition must be distinguished from the **diminished sexual interest and functioning that may accompany aging.**

Diagnostic Criteria for Sexual Dysfunction Due to . . . [Indicate the General Medical Condition]

A. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by the direct physiological effects of a general medical condition.

C. The disturbance is not better accounted for by another mental disorder (e.g., Major Depressive Disorder).

***Select* code and term based on the predominant sexual dysfunction:**

625.8 Female Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]:* if deficient or absent sexual desire is the predominant feature

608.89 Male Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]:* if deficient or absent sexual desire is the predominant feature

607.84 Male Erectile Disorder Due to . . . *[Indicate the General Medical Condition]:* if male erectile dysfunction is the predominant feature

625.0 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition]:* if pain associated with intercourse is the predominant feature

608.89 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition]:* if pain associated with intercourse is the predominant feature

625.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]:* if some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates

608.89 Other Male Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]:* if some other feature is predominant (e.g., Orgasmic Disorder) or no feature predominates

Coding note: Include the name of the general medical condition on Axis I, e.g., 607.84 Male Erectile Disorder Due to Diabetes Mellitus; also code the general medical

condition on Axis III (see Appendix G for codes).

Substance-Induced Sexual Dysfunction

Diagnostic Features

The essential feature of Substance-Induced Sexual Dysfunction is a clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty (Criterion A). Depending on the substance involved, the dysfunction may involve impaired desire, impaired arousal, impaired orgasm, or sexual pain. The dysfunction is judged to be fully explained by the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) (Criterion B). The disturbance must not be better accounted for by a Sexual Dysfunction that is not substance induced (Criterion C). This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the sexual symptoms are in excess of those usually associated with the intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. For a more detailed discussion of Substance-Related Disorders, See linked section.

A Substance-Induced Sexual Dysfunction is distinguished from a primary Sexual Dysfunction by considering onset and course. For drugs of abuse, there must be evidence of intoxication from the history, physical examination, or laboratory findings. Substance-Induced Sexual Dysfunctions arise only in association with intoxication, whereas primary Sexual Dysfunctions may precede the onset of substance use or occur during times of sustained abstinence from the substance. Factors suggesting that the dysfunction is better accounted for by a primary Sexual Dysfunction include persistence of the dysfunction for a substantial period of time (i.e., a month or more) after the end of Substance Intoxication; the development of a dysfunction that is substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary Sexual Dysfunctions.

Specifiers

The following specifiers for Substance-Induced Sexual Dysfunction are selected based

on the predominant sexual dysfunction. Although the clinical presentation of the sexual dysfunction may resemble one of the specific primary Sexual Dysfunctions, the full criteria for one of these disorders need not be met.

With Impaired Desire. This specifier is used if deficient or absent sexual desire is the predominant feature.
With Impaired Arousal. This specifier is used if impaired sexual arousal (e.g., erectile dysfunction, impaired lubrication) is the predominant feature.
With Impaired Orgasm. This specifier is used if impaired orgasm is the predominant feature.
With Sexual Pain. This specifier is used if pain associated with intercourse is the predominant feature.

Substance-Induced Sexual Dysfunctions usually have their onset during Substance Intoxication, and this may be indicated by noting **With Onset During Intoxication.**

Recording Procedures

The name of the Substance-Induced Sexual Dysfunction begins with the specific substance (e.g., alcohol, fluoxetine) that is presumed to be causing the sexual dysfunction. The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes (e.g., fluoxetine), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code on Axis I (see Appendix G). The name of the disorder is followed by the specification of predominant symptom presentation (e.g., 292.89 Cocaine-Induced Sexual Dysfunction, With Impaired Arousal). When more than one substance is judged to play a significant role in the development of the sexual dysfunction, each should be listed separately (e.g., 291.89 Alcohol-Induced Sexual Dysfunction, With Impaired Arousal; 292.89 Fluoxetine-Induced Sexual Dysfunction, With Impaired Orgasm). If a substance is judged to be the etiological factor, but the specific substance or class of substances is unknown, the category 292.89 Unknown Substance-Induced Sexual Dysfunction may be used.

Specific Substances

Sexual Dysfunctions can occur in association with **intoxication** with the following classes of substances: alcohol; amphetamine and related substances; cocaine; opioids; sedatives, hypnotics, and anxiolytics; and other or unknown substances. Acute intoxication with or chronic Abuse of or Dependence on substances of abuse has been reported to decrease sexual interest and cause arousal problems in both sexes. A decrease in sexual interest, arousal disorders, and orgasmic disorders may also be caused by prescribed medications including antihypertensives, histamine H_2 receptor antagonists, antidepressants (especially selective serotonin reuptake inhibitors), neuroleptics, anxiolytics, anabolic steroids, and antiepileptics. Painful orgasm has been reported with fluphenazine, thioridazine, and amoxapine. Priapism has been reported with use of chlorpromazine, trazodone, and clozapine and following penile injections of papaverine or prostaglandin. Medications such as antihypertensive agents or anabolic steroids may also promote depressed or irritable mood in addition to the sexual dysfunction, and an additional diagnosis of Substance-Induced Mood Disorder may be warranted. Current clinical experience strongly suggests that Substance-Induced Sexual Dysfunction is usually generalized (i.e., not limited to certain types of stimulation, situations, or partners).

Differential Diagnosis

Substance-induced sexual dysfunctions are most likely to occur during **Substance Intoxication.** The diagnosis of the substance-specific Intoxication will usually suffice to categorize the symptom presentation. A diagnosis of Substance-Induced Sexual Dysfunction should be made instead of a diagnosis of Substance Intoxication only when the dysfunction is judged to be in excess of that usually associated with the intoxication syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention. If psychological factors also play a role in the onset, severity, exacerbation, or maintenance of a sexual dysfunction, the diagnosis is the primary Sexual Dysfunction (with the subtype Due to Combined Factors).

A Substance-Induced Sexual Dysfunction is distinguished from a **primary Sexual Dysfunction** by the fact that the symptoms are judged to be fully explained by the direct effects of a substance (See linked section).

A Substance-Induced Sexual Dysfunction due to a prescribed treatment for a mental disorder or general medical condition must have its onset while the person is receiving the medication (e.g., antihypertensive medication). Once the treatment is discontinued, the sexual dysfunction will remit within days to several weeks (depending on the half-life

of the substance). If the sexual dysfunction persists, other causes for the dysfunction should be considered. Side effects of prescribed medications that affect sexual function may lead individuals to be noncompliant with the medication regimen if they value sexual performance over the benefits of the medication.

Because individuals with general medical conditions often take medications for those conditions, the clinician must consider the possibility that the sexual dysfunction is caused by the physiological consequences of the general medical condition rather than the medication, in which case **Sexual Dysfunction Due to a General Medical Condition** is diagnosed. The history often provides the primary basis for such a judgment. At times, a change in the treatment for the general medical condition (e.g., medication substitution or discontinuation) may be needed to determine empirically for that person whether the medication is the causative agent. If the clinician has ascertained that the dysfunction is due to both a general medical condition and substance use, both diagnoses (i.e., Sexual Dysfunction Due to a General Medical Condition and Substance-Induced Sexual Dysfunction) are given. When there is insufficient evidence to determine whether the Sexual Dysfunction is due to a substance (including a medication) or to a general medical condition or is primary (i.e., not due to either a substance or a general medical condition), **Sexual Dysfunction Not Otherwise Specified** would be indicated.

Diagnostic Criteria for Substance-Induced Sexual Dysfunction

A. Clinically significant sexual dysfunction that results in marked distress or interpersonal difficulty predominates in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the sexual dysfunction is fully explained by substance use as manifested by either (1) or (2):

1. the symptoms in Criterion A developed during, or within a month of, Substance Intoxication

2. medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by a Sexual Dysfunction that is not substance induced. Evidence that the symptoms are better accounted for by a Sexual Dysfunction that is not substance induced might include the following: the symptoms precede the onset of the substance use or dependence (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of intoxication, or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non-substance-induced Sexual Dysfunction (e.g., a history of recurrent non-substance-related episodes).

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication only when the sexual dysfunction is in excess of that usually associated with the intoxication syndrome and when the dysfunction is sufficiently severe to warrant independent clinical attention.

***Code* [Specific Substance]–Induced Sexual Dysfunction:**

(291.89 Alcohol; 292.89 Amphetamine [or Amphetamine-Like Substance]; 292.89 Cocaine; 292.89 Opioid; 292.89 Sedative, Hypnotic, or Anxiolytic; 292.89 Other [or Unknown] Substance)

***Specify* if:**

With Impaired Desire

With Impaired Arousal

With Impaired Orgasm

With Sexual Pain

***Specify* if:**

With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome

302.70 Sexual Dysfunction Not Otherwise Specified

This category includes sexual dysfunctions that do not meet criteria for any specific Sexual Dysfunction. Examples include

1. No (or substantially diminished) subjective erotic feelings despite otherwise-normal arousal and orgasm
2. Situations in which the clinician has concluded that a sexual dysfunction is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Paraphilias

Diagnostic Features

The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other nonconsenting persons that occur over a period of at least 6 months (Criterion A). For some individuals, paraphilic fantasies or stimuli are obligatory for erotic arousal and are always included in sexual activity. In other cases, the paraphilic preferences occur only episodically (e.g., perhaps during periods of stress), whereas at other times the person is able to function sexually without paraphilic fantasies or stimuli. For Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, the diagnosis is made if the person has acted on these urges or the urges or sexual fantasies cause marked distress or interpersonal difficulty. For Sexual Sadism, the diagnosis is made if the person has acted on these urges with a nonconsenting person or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty. For the remaining Paraphilias, the diagnosis is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in

social, occupational, or other important areas of functioning (Criterion B).

Paraphilic imagery may be acted out with a nonconsenting partner in a way that may be injurious to the partner (as in Sexual Sadism or Pedophilia). The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts, and individuals with Exhibitionism, Pedophilia, and Voyeurism make up the majority of apprehended sex offenders. In some situations, acting out the paraphilic imagery may lead to self-injury (as in Sexual Masochism). Social and sexual relationships may suffer if others find the unusual sexual behavior shameful or repugnant or if the individual's sexual partner refuses to cooperate in the unusual sexual preferences. In some instances, the unusual behavior (e.g., exhibitionistic acts or the collection of fetish objects) may become the major sexual activity in the individual's life. These individuals are rarely self-referred and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with sexual partners or society.

The Paraphilias described here are conditions that have been specifically identified by previous classifications. They include Exhibitionism (exposure of genitals), Fetishism (use of nonliving objects), Frotteurism (touching and rubbing against a nonconsenting person), Pedophilia (focus on prepubescent children), Sexual Masochism (receiving humiliation or suffering), Sexual Sadism (inflicting humiliation or suffering), Transvestic Fetishism (cross-dressing), and Voyeurism (observing sexual activity). A residual category, Paraphilia Not Otherwise Specified, includes other Paraphilias that are less frequently encountered. Not uncommonly, individuals have more than one Paraphilia.

Recording Procedures

The individual Paraphilias are differentiated based on the characteristic paraphilic focus. However, if the individual's sexual preferences meet criteria for more than one Paraphilia, all should be diagnosed. The diagnostic code and terms are as follows: 302.4 Exhibitionism, 302.81 Fetishism, 302.89 Frotteurism, 302.2 Pedophilia, 302.83 Sexual Masochism, 302.84 Sexual Sadism, 302.3 Transvestic Fetishism, 302.82 Voyeurism, and 302.9 Paraphilia Not Otherwise Specified.

Associated Features and Disorders

Associated descriptive features and mental disorders. The preferred stimulus, even

within a particular Paraphilia, may be highly specific. Individuals who do not have a consenting partner with whom their fantasies can be acted out may purchase the services of prostitutes or may act out their fantasies with unwilling victims. Individuals with a Paraphilia may select an occupation or develop a hobby or volunteer work that brings them into contact with the desired stimulus (e.g., selling women's shoes or lingerie [Fetishism], working with children [Pedophilia], or driving an ambulance [Sexual Sadism]). They may selectively view, read, purchase, or collect photographs, films, and textual depictions that focus on their preferred type of paraphilic stimulus. Many individuals with these disorders assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior. Others report extreme guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable or that they regard as immoral. There is often impairment in the capacity for reciprocal, affectionate sexual activity, and Sexual Dysfunctions may be present. Personality disturbances are also frequent and may be severe enough to warrant a diagnosis of a Personality Disorder. Symptoms of depression may develop in individuals with Paraphilias and may be accompanied by an increase in the frequency and intensity of the paraphilic behavior.

Associated laboratory findings. Penile plethysmography has been used in research settings to assess various Paraphilias by measuring an individual's sexual arousal in response to visual and auditory stimuli. The reliability and validity of this procedure in clinical assessment have not been well established, and clinical experience suggests that subjects can simulate response by manipulating mental images.

Associated general medical conditions. Frequent, unprotected sex may result in infection with, or transmission of, a sexually transmitted disease. Sadistic or masochistic behaviors may lead to injuries ranging in extent from minor to life threatening.

Specific Culture and Gender Features

The diagnosis of Paraphilias across cultures or religions is complicated by the fact that what is considered deviant in one cultural setting may be more acceptable in another setting. Except for Sexual Masochism, where the sex ratio is estimated to be 20 males for each female, the other Paraphilias are almost never diagnosed in females, although

some cases have been reported.

Prevalence

Although Paraphilias are rarely diagnosed in general clinical facilities, the large commercial market in paraphilic pornography and paraphernalia suggests that its prevalence in the community is likely to be higher. The most common presenting problems in clinics that specialize in the treatment of Paraphilias are Pedophilia, Voyeurism, and Exhibitionism. Sexual Masochism and Sexual Sadism are much less commonly seen. Approximately one-half of the individuals with Paraphilias seen clinically are married.

Course

Certain of the fantasies and behaviors associated with Paraphilias may begin in childhood or early adolescence but become better defined and elaborated during adolescence and early adulthood. Elaboration and revision of paraphilic fantasies may continue over the lifetime of the individual. By definition, the fantasies and urges associated with these disorders are recurrent. Many individuals report that the fantasies are always present but that there are periods of time when the frequency of the fantasies and intensity of the urges vary substantially. The disorders tend to be chronic and lifelong, but both the fantasies and the behaviors often diminish with advancing age in adults. The behaviors may increase in response to psychosocial stressors, in relation to other mental disorders, or with increased opportunity to engage in the Paraphilia.

Differential Diagnosis

A Paraphilia must be distinguished from the **nonpathological use of sexual fantasies, behaviors, or objects as a stimulus for sexual excitement** in individuals without a Paraphilia. Fantasies, behaviors, or objects are paraphilic only when they lead to clinically significant distress or impairment (e.g., are obligatory, result in sexual dysfunction, require participation of nonconsenting individuals, lead to legal complications, interfere with social relationships).

In **Mental Retardation, Dementia, Personality Change Due to a General Medical**

Condition, Substance Intoxication, a **Manic Episode**, or **Schizophrenia,** there may be a decrease in judgment, social skills, or impulse control that, in rare instances, leads to unusual sexual behavior. This can be distinguished from a Paraphilia by the fact that the unusual sexual behavior is not the individual's preferred or obligatory pattern, the sexual symptoms occur exclusively during the course of these mental disorders, and the unusual sexual acts tend to be isolated rather than recurrent and usually have a later age at onset.

The individual Paraphilias can be distinguished based on differences in the characteristic paraphilic focus. However, if the individual's sexual preferences meet criteria for more than one Paraphilia, all can be diagnosed. **Exhibitionism** must be distinguished from **public urination,** which is sometimes offered as an explanation for the behavior. **Fetishism** and **Transvestic Fetishism** both often involve articles of feminine clothing. In Fetishism, the focus of sexual arousal is on the article of clothing itself (e.g., panties), whereas in Transvestic Fetishism the sexual arousal comes from the act of cross-dressing. Cross-dressing, which is present in **Transvestic Fetishism,** may also be present in **Sexual Masochism.** In Sexual Masochism, it is the humiliation of being forced to cross-dress, not the garments themselves, that is sexually exciting.

Cross-dressing may be associated with gender dysphoria. If some gender dysphoria is present but the full criteria for Gender Identity Disorder are not met, the diagnosis is **Transvestic Fetishism, With Gender Dysphoria.** Individuals should receive the additional diagnosis of **Gender Identity Disorder** if their presentation meets the full criteria for Gender Identity Disorder.

302.4 Exhibitionism

The paraphilic focus in Exhibitionism involves the exposure of one's genitals to a stranger. Sometimes the individual masturbates while exposing himself (or while fantasizing exposing himself). If the person acts on these urges, there is generally no attempt at further sexual activity with the stranger. In some cases, the individual is aware of a desire to surprise or shock the observer. In other cases, the individual has the sexually arousing fantasy that the observer will become sexually aroused. The onset usually occurs before age 18 years, although it can begin at a later age. Few arrests are made in the older age groups, which may suggest that the condition becomes less severe after age 40 years.

Diagnostic Criteria for 302.4 Exhibitionism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the exposure of one's genitals to an unsuspecting stranger.

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.81 Fetishism

The paraphilic focus in Fetishism involves the use of nonliving objects (the "fetish"). Among the more common fetish objects are women's underpants, bras, stockings, shoes, boots, or other wearing apparel. The person with Fetishism frequently masturbates while holding, rubbing, or smelling the fetish object or may ask the sexual partner to wear the object during their sexual encounters. Usually the fetish is required or strongly preferred for sexual excitement, and in its absence there may be erectile dysfunction in males. This Paraphilia is not diagnosed when the fetishes are limited to articles of female clothing used in cross-dressing, as in Transvestic Fetishism, or when the object is genitally stimulating because it has been designed for that purpose (e.g., a vibrator). Usually the Paraphilia begins by adolescence, although the fetish may have been endowed with special significance earlier in childhood. Once established, Fetishism tends to be chronic.

Diagnostic Criteria for 302.81 Fetishism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the use of nonliving objects (e.g., female undergarments).

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The fetish objects are not limited to articles of female clothing used in cross-dressing (as in Transvestic Fetishism) or devices designed for the purpose of tactile genital stimulation (e.g., a vibrator).

302.89 Frotteurism

The paraphilic focus of Frotteurism involves touching and rubbing against a nonconsenting person. The behavior usually occurs in crowded places from which the individual can more easily escape arrest (e.g., on busy sidewalks or in public transportation vehicles). He rubs his genitals against the victim's thighs and buttocks or fondles her genitalia or breasts with his hands. While doing this he usually fantasizes an exclusive, caring relationship with the victim. However, he recognizes that to avoid possible prosecution, he must escape detection after touching his victim. Usually the paraphilia begins by adolescence. Most acts of frottage occur when the person is ages 15–25 years, after which there is a gradual decline in frequency.

Diagnostic Criteria for 302.89 Frotteurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving touching and rubbing against a nonconsenting person.

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.2 Pedophilia

The paraphilic focus of Pedophilia involves sexual activity with a prepubescent child (generally age 13 years or younger). The individual with Pedophilia must be age 16 years or older and at least 5 years older than the child. For individuals in late adolescence with Pedophilia, no precise age difference is specified, and clinical judgment must be used; both the sexual maturity of the child and the age difference must be taken into account. Individuals with Pedophilia generally report an attraction to children of a particular age range. Some individuals prefer males, others females, and some are aroused by both males and females. Those attracted to females usually prefer 8- to 10-year-olds, whereas those attracted to males usually prefer slightly older children. Pedophilia involving female victims is reported more often than Pedophilia involving male victims. Some individuals with Pedophilia are sexually attracted only to children (Exclusive Type), whereas others are sometimes attracted to adults (Nonexclusive Type). Individuals with Pedophilia who act on their urges with children may limit their activity to undressing the child and looking, exposing themselves, masturbating in the presence of the child, or gentle touching and fondling of the child. Others, however, perform fellatio or cunnilingus on the child or penetrate the child's vagina, mouth, or anus with their fingers, foreign objects, or penis and use varying degrees of force to do so. These activities are commonly explained with excuses or rationalizations that they have "educational value" for the child, that the child derives "sexual pleasure" from them, or that the child was "sexually provocative"—themes that are also common in pedophilic pornography. Because of the ego-syntonic nature of Pedophilia, many individuals with pedophilic fantasies, urges, or behaviors do not experience significant distress. It is important to understand that experiencing distress about having the fantasies, urges, or behaviors is not necessary for a diagnosis of Pedophilia. Individuals who have a pedophilic arousal pattern and act on these fantasies or urges with a child qualify for the diagnosis of Pedophilia.

Individuals may limit their activities to their own children, stepchildren, or relatives or may victimize children outside their families. Some individuals with Pedophilia threaten the child to prevent disclosure. Others, particularly those who frequently victimize children, develop complicated techniques for obtaining access to children, which may include winning the trust of a child's mother, marrying a woman with an attractive child, trading children with other individuals with Pedophilia, or, in rare instances, taking in

foster children from nonindustrialized countries or abducting children from strangers. Except in cases in which the disorder is associated with Sexual Sadism, the person may be attentive to the child's needs in order to gain the child's affection, interest, and loyalty and to prevent the child from reporting the sexual activity. The disorder usually begins in adolescence, although some individuals with Pedophilia report that they did not become aroused by children until middle age. The frequency of pedophilic behavior often fluctuates with psychosocial stress. The course is usually chronic, especially in those attracted to males. The recidivism rate for individuals with Pedophilia involving a preference for males is roughly twice that for those who prefer females.

Diagnostic Criteria for 302.2 Pedophilia

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 years or younger).

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

C. The person is at least age 16 years and at least 5 years older than the child or children in Criterion A.

Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old.

***Specify* if:**

Sexually Attracted to Males

Sexually Attracted to Females

Sexually Attracted to Both

***Specify* if:**

Limited to Incest

***Specify* type:**

Exclusive Type (attracted only to children)

Nonexclusive Type

302.83 Sexual Masochism

The paraphilic focus of Sexual Masochism involves the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer. Some individuals are bothered by their masochistic fantasies, which may be invoked during sexual intercourse or masturbation but not otherwise acted on. In such cases, the masochistic fantasies usually involve being raped while being held or bound by others so that there is no possibility of escape. Others act on the masochistic sexual urges by themselves (e.g., binding themselves, sticking themselves with pins, shocking themselves electrically, or self-mutilation) or with a partner. Masochistic acts that may be sought with a partner include restraint (physical bondage), blindfolding (sensory bondage), paddling, spanking, whipping, beating, electrical shocks, cutting, "pinning and piercing" (infibulation), and humiliation (e.g., being urinated or defecated on, being forced to crawl and bark like a dog, or being subjected to verbal abuse). Forced cross-dressing may be sought for its humiliating associations. The individual may have a desire to be treated as a helpless infant and clothed in diapers ("infantilism"). One particularly dangerous form of Sexual Masochism, called "hypoxyphilia," involves sexual arousal by oxygen deprivation obtained by means of chest compression, noose, ligature, plastic bag, mask, or chemical (often a volatile nitrite that produces a temporary decrease in brain oxygenation by peripheral vasodilation). Oxygen-depriving activities may be engaged in alone or with a partner. Because of equipment malfunction, errors in the placement of the noose or ligature, or other mistakes, accidental deaths sometimes occur. Data from the United States, England, Australia, and Canada indicate that one to two hypoxyphilia-caused deaths per million population are detected and reported each year. Some males with Sexual Masochism also have Fetishism, Transvestic Fetishism, or Sexual Sadism. Masochistic sexual fantasies are likely to have been present in childhood. The age at which masochistic activities with partners first begins is variable, but is commonly by early adulthood. Sexual Masochism is usually chronic, and the person tends to repeat the same masochistic act. Some individuals with Sexual Masochism may engage in masochistic acts for many years without increasing the potential injuriousness of their acts. Others, however, increase the severity of the masochistic acts over time or during periods of stress, which may eventually result in injury or even death.

Diagnostic Criteria for 302.83 Sexual Masochism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

302.84 Sexual Sadism

The paraphilic focus of Sexual Sadism involves acts (real, not simulated) in which the individual derives sexual excitement from the psychological or physical suffering (including humiliation) of the victim. Some individuals with this Paraphilia are bothered by their sadistic fantasies, which may be invoked during sexual activity but not otherwise acted on; in such cases the sadistic fantasies usually involve having complete control over the victim, who is terrified by anticipation of the impending sadistic act. Others act on the sadistic sexual urges with a consenting partner (who may have Sexual Masochism) who willingly suffers pain or humiliation. Still others with Sexual Sadism act on their sadistic sexual urges with nonconsenting victims. In all of these cases, it is the suffering of the victim that is sexually arousing. Sadistic fantasies or acts may involve activities that indicate the dominance of the person over the victim (e.g., forcing the victim to crawl or keeping the victim in a cage). They may also involve restraint, blindfolding, paddling, spanking, whipping, pinching, beating, burning, electrical shocks, rape, cutting, stabbing, strangulation, torture, mutilation, or killing. Sadistic sexual fantasies are likely to have been present in childhood. The age at onset of sadistic activities is variable, but is commonly by early adulthood. Sexual Sadism is usually chronic. When Sexual Sadism is practiced with nonconsenting partners, the activity is likely to be repeated until the person with Sexual Sadism is apprehended. Some individuals with Sexual Sadism may engage in sadistic acts for many years without a need to increase the potential for inflicting serious physical damage. Usually, however, the severity of the sadistic acts increases over time. When Sexual Sadism is severe, and especially when it is associated with Antisocial Personality Disorder, individuals with Sexual Sadism may seriously injure or kill their victims.

Diagnostic Criteria for 302.84 Sexual Sadism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving acts (real, not simulated) in which the psychological or physical suffering (including humiliation) of the victim is sexually exciting to the person.

B. The person has acted on these sexual urges with a nonconsenting person, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.3 Transvestic Fetishism

The paraphilic focus of Transvestic Fetishism involves cross-dressing by a male in women's attire. In many or most cases, sexual arousal is produced by the accompanying thought or image of the person as a female (referred to as "autogynephilia"). These images can range from being a woman with female genitalia to that of a view of the self fully dressed as a woman with no real attention to genitalia. Women's garments are arousing primarily as symbols of the individual's femininity, not as fetishes with specific objective properties (e.g., objects made of rubber). Usually the male with Transvestic Fetishism keeps a collection of female clothes that he intermittently uses to cross-dress. This disorder has been described only in heterosexual males. Transvestic Fetishism is not diagnosed when cross-dressing occurs exclusively during the course of Gender Identity Disorder. Transvestic phenomena range from occasional solitary wearing of female clothes to extensive involvement in a transvestic subculture. Some males wear a single item of women's apparel (e.g., underwear or hosiery) under their masculine attire. Other males with Transvestic Fetishism dress entirely as females and wear makeup. The degree to which the cross-dressed individual successfully appears to be a female varies, depending on mannerisms, body habitus, and cross-dressing skill. When not cross-dressed, the male with Transvestic Fetishism is usually unremarkably masculine. Although his basic preference is heterosexual, he tends to have few sexual partners and may have engaged in occasional homosexual acts. An associated feature may be the presence of Sexual Masochism. The disorder typically begins with cross-dressing in childhood or early adolescence. In many cases, the cross-dressing is not done in public until adulthood. The initial experience may involve partial or total cross-dressing; partial cross-dressing often progresses to complete cross-dressing. A favored article of clothing may become erotic in itself and may be used habitually, first in masturbation and later in intercourse. In some individuals, the motivation for cross-dressing may change over time, temporarily or permanently, with sexual arousal in response to the cross-dressing diminishing or disappearing. In such instances, the cross-dressing becomes an antidote to anxiety or depression or contributes to a sense of peace and calm. In other individuals, gender dysphoria may emerge, especially under situational stress with or without symptoms of depression. For a small number of individuals, the gender dysphoria becomes a fixed part of the clinical picture and is accompanied by the desire to dress and live permanently as a female and to seek hormonal or surgical reassignment. Individuals with Transvestic Fetishism often seek treatment when gender

dysphoria emerges. The subtype With Gender Dysphoria is provided to allow the clinician to note the presence of gender dysphoria as part of Transvestic Fetishism.

Diagnostic Criteria for 302.3 Transvestic Fetishism

A. Over a period of at least 6 months, in a heterosexual male, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving cross-dressing.

B. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

***Specify* if:**

With Gender Dysphoria: if the person has persistent discomfort with gender role or identity

302.82 Voyeurism

The paraphilic focus of Voyeurism involves the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and generally no sexual activity with the observed person is sought. Orgasm, usually produced by masturbation, may occur during the voyeuristic activity or later in response to the memory of what the person has witnessed. Often these individuals have the fantasy of having a sexual experience with the observed person, but in reality this rarely occurs. In its severe form, peeping constitutes the exclusive form of sexual activity. The onset of voyeuristic behavior is usually before age 15 years. The course tends to be chronic.

Diagnostic Criteria for 302.82 Voyeurism

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving the act of observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

B. The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty.

302.9 Paraphilia Not Otherwise Specified

This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to, telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Gender Identity Disorders

Gender Identity Disorder

Diagnostic Features

There are two components of Gender Identity Disorder, both of which must be present to make the diagnosis. There must be evidence of a strong and persistent cross-gender identification, which is the desire to be, or the insistence that one is, of the other sex (Criterion A). This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex. There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex (Criterion B). The diagnosis is not made if the individual has a concurrent physical intersex condition (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia) (Criterion C). To make the diagnosis, there must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion D).

In boys, the cross-gender identification is manifested by a marked preoccupation with

traditionally feminine activities. They may have a preference for dressing in girls' or women's clothes or may improvise such items from available materials when genuine articles are unavailable. Towels, aprons, and scarves are often used to represent long hair or skirts. There is a strong attraction for the stereotypical games and pastimes of girls. They particularly enjoy playing house, drawing pictures of beautiful girls and princesses, and watching television or videos of their favorite female characters. Stereotypical female-type dolls, such as Barbie, are often their favorite toys, and girls are their preferred playmates. When playing "house," these boys role-play female figures, most commonly "mother roles," and often are quite preoccupied with female fantasy figures. They avoid rough-and-tumble play and competitive sports and have little interest in cars and trucks or other nonaggressive but stereotypical boys' toys. They may express a wish to be a girl and assert that they will grow up to be a woman. They may insist on sitting to urinate and pretend not to have a penis by pushing it in between their legs. More rarely, boys with Gender Identity Disorder may state that they find their penis or testes disgusting, that they want to remove them, or that they have, or wish to have, a vagina.

Girls with Gender Identity Disorder display intense negative reactions to parental expectations or attempts to have them wear dresses or other feminine attire. Some may refuse to attend school or social events where such clothes may be required. They prefer boys' clothing and short hair, are often misidentified by strangers as boys, and may ask to be called by a boy's name. Their fantasy heroes are most often powerful male figures, such as Batman or Superman. These girls prefer boys as playmates, with whom they share interests in contact sports, rough-and-tumble play, and traditional boyhood games. They show little interest in dolls or any form of feminine dress-up or role-play activity. A girl with this disorder may occasionally refuse to urinate in a sitting position. She may claim that she has or will grow a penis and may not want to grow breasts or to menstruate. She may assert that she will grow up to be a man. Such girls typically reveal marked cross-gender identification in role-playing, dreams, and fantasies.

Adults with Gender Identity Disorder are preoccupied with their wish to live as a member of the other sex. This preoccupation may be manifested as an intense desire to adopt the social role of the other sex or to acquire the physical appearance of the other sex through hormonal or surgical manipulation. Adults with this disorder are uncomfortable being regarded by others as, or functioning in society as, a member of their designated sex. To varying degrees, they adopt the behavior, dress, and mannerisms of the other sex. In private, these individuals may spend much time cross-dressed and working on the appearance of being the other sex. Many attempt to pass in public as the other sex. With cross-dressing and hormonal treatment (and for males, electrolysis), many individuals with this disorder may pass convincingly as the other sex.

The sexual activity of these individuals with same-sex partners is generally constrained by the preference that their partners neither see nor touch their genitals. For some males who present later in life (often following marriage), the individual's sexual activity with a woman is accompanied by the fantasy of being lesbian lovers or that his partner is a man and he is a woman.

In adolescents, the clinical features may resemble either those of children or those of adults, depending on the individual's developmental level, and the criteria should be applied accordingly. In a younger adolescent, it may be more difficult to arrive at an accurate diagnosis because of the adolescent's guardedness. This may be increased if the adolescent feels ambivalent about cross-gender identification or feels that it is unacceptable to the family. The adolescent may be referred because the parents or teachers are concerned about social isolation or peer teasing and rejection. In such circumstances, the diagnosis should be reserved for those adolescents who appear quite cross-gender identified in their dress and who engage in behaviors that suggest significant cross-gender identification (e.g., shaving legs in males). Clarifying the diagnosis in children and adolescents may require monitoring over an extended period of time.

Distress or disability in individuals with Gender Identity Disorder is manifested differently across the life cycle. In young children, distress is manifested by the stated unhappiness about their assigned sex. Preoccupation with cross-gender wishes often interferes with ordinary activities. In older children, failure to develop age-appropriate same-sex peer relationships and skills often leads to isolation and distress, and some children may refuse to attend school because of teasing or pressure to dress in attire stereotypical of their assigned sex. In adolescents and adults, preoccupation with cross-gender wishes often interferes with ordinary activities. Relationship difficulties are common, and functioning at school or at work may be impaired.

Specifiers

For sexually mature individuals, the following specifiers may be noted based on the individual's sexual orientation: **Sexually Attracted to Males, Sexually Attracted to Females, Sexually Attracted to Both,** and **Sexually Attracted to Neither.** Males with Gender Identity Disorder include substantial proportions with all four specifiers. Those who are attracted to males usually first experience the disorder beginning in childhood or early adolescence, while those males attracted to females, both genders, or neither usually report their gender dysphoria beginning in early to mid-adulthood. Those men

attracted to neither gender are often isolated individuals with schizoid traits. Virtually all females with Gender Identity Disorder will receive the same specifier—Sexually Attracted to Females—although there are exceptional cases involving females who are Sexually Attracted to Males.

Recording Procedures

The assigned diagnostic code depends on the individual's current age: if the disorder occurs in childhood, the code 302.6 is used; for an adolescent or adult, 302.85 is used.

Associated Features and Disorders

Associated descriptive features and mental disorders. Many individuals with Gender Identity Disorder become socially isolated. Isolation and ostracism contribute to low self-esteem and may lead to school aversion or dropping out of school. Peer ostracism and teasing are especially common sequelae for boys with the disorder. Boys with Gender Identity Disorder often show marked feminine mannerisms and speech patterns.

The disturbance can be so pervasive that the mental lives of some individuals revolve only around those activities that lessen gender distress. They are often preoccupied with appearance, especially early in the transition to living in the opposite sex role. Relationships with one or both parents also may be seriously impaired. Some males with Gender Identity Disorder resort to self-treatment with hormones and may very rarely perform their own castration or penectomy. Especially in urban centers, some males with the disorder may engage in prostitution, which places them at high risk for human immunodeficiency virus (HIV) infection. Suicide attempts and Substance-Related Disorders are commonly associated.

Children with Gender Identity Disorder may manifest coexisting Separation Anxiety Disorder, Generalized Anxiety Disorder, and symptoms of depression. Adolescents are particularly at risk for depression and suicidal ideation and suicide attempts. In adults, anxiety and depressive symptoms may be present. In clinical samples, associated Personality Disorders are more common among males than among females. Adult males who are sexually attracted to females, to both males and females, or to neither sex usually report a history of erotic arousal associated with the thought or image of oneself as a woman (termed *autogynephilia*). In most cases, the individual would qualify, at least

in his past, for a diagnosis of Transvestic Fetishism. In others, however, the individual's favorite fantasy emphasizes feminine attributes other than clothing. Some men, for example, masturbate while picturing themselves as nude women, focusing on their imagined breasts and vulvas; others masturbate while picturing themselves engaged in some stereotypically feminine activity such as knitting.

Associated laboratory findings. There is no diagnostic test specific for Gender Identity Disorder. In the presence of a normal physical examination, karyotyping for sex chromosomes and sex hormone assays are usually not indicated. Psychological testing may reveal cross-gender identification or behavior patterns.

Associated physical examination findings and general medical conditions. Individuals with Gender Identity Disorder have normal genitalia (in contrast to the ambiguous genitalia or hypogonadism found in physical intersex conditions). Adolescent and adult males with Gender Identity Disorder may show breast enlargement resulting from hormone ingestion, hair denuding from temporary or permanent epilation, and other physical changes as a result of procedures such as rhinoplasty or thyroid cartilage shaving (surgical reduction of the Adam's apple). Distorted breasts or breast rashes may be seen in females who wear breast binders. Postsurgical complications in genetic females include prominent chest wall scars, and in genetic males, vaginal strictures, rectovaginal fistulas, urethral stenoses, and misdirected urinary streams. Adult females with Gender Identity Disorder may have a higher-than-expected likelihood of polycystic ovarian disease.

Specific Age and Gender Features

Females with Gender Identity Disorders generally experience less ostracism because of cross-gender interests and may suffer less from peer rejection, at least until adolescence. In child clinic samples, boys with this disorder are referred for evaluation much more frequently than are girls. In adult clinic samples, men outnumber women by about two or three times. In children, the referral bias toward males may partly reflect the greater stigma that cross-gender behavior carries for boys than for girls.

Prevalence

There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.

Course

For clinically referred children, onset of cross-gender interests and activities is usually between ages 2 and 4 years, and some parents report that their child has always had cross-gender interests. Only a very small number of children with Gender Identity Disorder will continue to have symptoms that meet criteria for Gender Identity Disorder in adolescence or adulthood. Typically, children are referred around the time of school entry because of parental concern that what they regarded as a "phase" does not appear to be passing. Most children with Gender Identity Disorder display less overt cross-gender behaviors with time, parental intervention, or response from peers. By late adolescence or adulthood, about three-quarters of boys who had a childhood history of Gender Identity Disorder report a homosexual or bisexual orientation, but without concurrent Gender Identity Disorder. Most of the remainder report a heterosexual orientation, also without concurrent Gender Identity Disorder. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.

In adult males, there are two different courses for the development of Gender Identity Disorder. The first is a continuation of Gender Identity Disorder that had an onset in childhood. These individuals typically present in late adolescence or adulthood. In the other course, the more overt signs of cross-gender identification appear later and more gradually, with a clinical presentation in early to mid-adulthood usually following, but sometimes concurrent with, Transvestic Fetishism. The later-onset group may be more fluctuating in the degree of cross-gender identification, more ambivalent about sex-reassignment surgery, more likely to be sexually attracted to women, and less likely to be satisfied after sex-reassignment surgery. Males with Gender Identity Disorder who are sexually attracted to males tend to present in adolescence or early adulthood with a lifelong history of gender dysphoria. In contrast, those who are sexually attracted to females, to both males and females, or to neither sex tend to present later and typically

have a history of Transvestic Fetishism. Typically, after sex reassignment, those males who were attracted to females wish to live with another woman in either a lesbian relationship or as sisters. If Gender Identity Disorder is present in adulthood, it tends to have a chronic course, but spontaneous remission has been reported.

Differential Diagnosis

Gender Identity Disorder can be distinguished from simple **nonconformity to stereotypical sex-role behavior** by the extent and pervasiveness of the cross-gender wishes, interests, and activities. This disorder is not meant to describe a child's nonconformity to stereotypic sex-role behavior as, for example, in "tomboyishness" in girls or "sissyish" behavior in boys. Rather, it represents a profound disturbance of the individual's sense of identity with regard to maleness or femaleness. Behavior in children that merely does not fit the cultural stereotype of masculinity or femininity should not be given the diagnosis unless the full syndrome is present, including marked distress or impairment.

Transvestic Fetishism occurs in heterosexual (or bisexual) men for whom the cross-dressing behavior is for the purpose of sexual excitement. Aside from cross-dressing, most individuals with Transvestic Fetishism do not have a history of childhood cross-gender behaviors. Males with a presentation that meets full criteria for Gender Identity Disorder as well as Transvestic Fetishism should be given both diagnoses. If gender dysphoria is present in an individual with Transvestic Fetishism but full criteria for Gender Identity Disorder are not met, the specifier With Gender Dysphoria can be used.

The category **Gender Identity Disorder Not Otherwise Specified** can be used for individuals who have a gender identity problem with a **concurrent congenital intersex condition** (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia).

In **Schizophrenia,** there may rarely be delusions of belonging to the other sex. Insistence by a person with a Gender Identity Disorder that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist.

Diagnostic Criteria for Gender Identity Disorder

A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).

In children, the disturbance is manifested by four (or more) of the following:

1. repeatedly stated desire to be, or insistence that he or she is, the other sex

2. in boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing

3. strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex

4. intense desire to participate in the stereotypical games and pastimes of the other sex

5. strong preference for playmates of the other sex

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.
In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
C. The disturbance is not concurrent with a physical intersex condition.

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

***Code* based on current age:**

302.6 Gender Identity Disorder in Children
302.85 Gender Identity Disorder in Adolescents or Adults

***Specify* if (for sexually mature individuals):**

Sexually Attracted to Males

Sexually Attracted to Females

Sexually Attracted to Both

Sexually Attracted to Neither

302.6 Gender Identity Disorder Not Otherwise Specified

This category is included for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder. Examples include

1. Intersex conditions (e.g., partial androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria
2. Transient, stress-related cross-dressing behavior
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex

302.9 Sexual Disorder Not Otherwise Specified

This category is included for coding a sexual disturbance that does not meet the criteria for any specific Sexual Disorder and is neither a Sexual Dysfunction nor a Paraphilia. Examples include

1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual only as things to be used
3. Persistent and marked distress about sexual orientation