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Peer Commentaries on Binik (2005)

A move to the Pain Disorders category of the DSM-V would take dyspareunia out of the manual altogether and, in effect, air brush it out of the research and clinical picture. The Pain Disorder category of the current version of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) does not list any specific pains. No one would recognize it as the new home of dyspareunia. It is difficult to fathom how that would engender more research or clinical interest of any variety. As a matter of fact, one could easier make an argument to eliminate the Pain Disorder category altogether, considering the current criteria fit anyone who has ever been in any significant pain at any time. A second concern is one of overstating the primacy of the pain in dyspareunia, to the detriment of sexual function considerations. Even if we consider dyspareunia to be primarily a pain disorder, it is a pain disorder that interferes with sexual function in a more direct fashion than most. “Not tonight, dear, I have a headache” augers a touch better than “Not ever, dear, I have dyspareunia.” Finally, the move to the Pain Disorders category raises concerns about the increasing medicalization of problems that impact on sexual function (Tiefer, 2001b). The medical attribution is validating for many women (Meana, Binik, Khalifé, & Cohen, 1999), but it risks a decontextualization that will divorce the problem from its true complexity and result in sub-optimal outcomes.

Balancing Concerns While Waiting for More Data

It seems the pendulum has swung from considerations of dyspareunia as a pain that manifests deeply seated psychosexual conflicts to dyspareunia as a pain like any other, with an unfortunate yet incidental relation to sexual function. The trajectory is understandable and has borne fruit; however, the maturing of this idea now calls for a more integrated approach to both questions of sex and of pain and the complexities of the context in which they both happen. First, we have to throw the net a little wider to truly understand the pain and the sex of dyspareunia. VVS is only part of the catch. And if we are intent on re-classification, it seems there is at least one alternative that does not risk the loss of visibility, neglect of sexual impact, and the over-medicalization attendant in the move to the Pain Disorders: Keep dyspareunia within the Sexual Dysfunction category of the DSM-V, but change the “Sexual Pain Disorders” to “Pain Disorders Impacting on Sexual Function.” Although not perfectly capturing the probable bi-directionality of sex and pain, this new sub-category would achieve at least three seemingly worthwhile goals: (1) it would account

for both the pain and sexual components of dyspareunia and vaginismus; (2) it would eliminate the theoretically and empirically unsound concept of “sexual pain” and; (3) it would open up the diagnosis and treatment for other pain disorders interacting with sexual function. There are surely other potential solutions to this taxonomical conundrum, but we need to remain vigilant to the pull of dichotomies. It is crucial that our zeal to give the pain of dyspareunia its research and clinical due does not result in the creation of new but also misguided dualisms.

Dyspareunia: Another Argument for Removal

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Binik’s recommendation that Dyspareunia be removed from the Sexual Dysfunction section of the DSM supports my previous criticisms of the Sexual and Gender Identity Disorders diagnostic category in the DSM. The DSM is the result of faulty logic, inconsistent thinking, and does not adhere to its own standards. The classification of “sexual” disorders as distinct and different from the various other categories of the DSM has been random, inconsistent, arbitrary, and politically motivated (Moser, 2001, 2002; Moser & Kleinplatz, in press).

The text of the DSM acknowledges that “the utility and credibility of the DSM-IV-TR require it . . . be supported by an extensive empirical foundation” (American Psychiatric Association, 2000, p. xxiii), but my own literature search found no support for separating Dyspareunia from other pain disorders or designating it as a Sexual Dysfunction. In short, why should psychosomatic genital pain be classified differently from psychosomatic chest pain, if both “. . . are associated with sexual intercourse” (American Psychiatric Association, 2000, p. 566)?

The stated goal of the DSM-IV is “. . . to provide a helpful guide to clinical practice . . . and . . . clarity” (American Psychiatric Association, 2000, p. xxiii), but, as Binik demonstrates, defining Dyspareunia as a sexual dysfunction has not guided clinical practice or provided clarity. The result has been to limit the application of pain management techniques and the chronic pain perspective to this problem. Clinical implications of the current nosology are discussed elsewhere in this issue by Kleinplatz (2005).

It is important to understand the historical evolution of Dyspareunia in the DSM, how it became a sexual disorder, and how the sexual disorders were separated

from other psychiatric diagnoses. In the DSM-I, under “Psychophysiological Autonomic and Visceral Disorders” (American Psychiatric Association, 1952, p. 29), different psychophysiological reactions were listed by organ system (e.g., respiratory, gastrointestinal, cardiovascular). Dyspareunia was not specifically named, but logically would have been listed under “genitourinary reaction.” In the DSM-II, the name of the category was shortened to “Psychophysiological Disorders” and “genito-urinary disorder” now specifically included both impotence and dyspareunia (American Psychiatric Association, 1968, pp. 46–47). Both the DSM-I and II contained the phrase “. . . in which emotional factors play a causative role” (American Psychiatric Association, 1952, p. 30; American Psychiatric Association, 1968, p. 47) to emphasize the requirement that the pain or physical symptoms had a psychiatric origin.

The DSM-III (American Psychiatric Association, 1980) was a complete conceptual revision of the DSM. It was an attempt to create an atheoretical document, specifically removing psychoanalytic language and diagnostic groupings which dominated earlier editions of the DSM. A conscious decision was made, “. . . to group all the sexual disorders together” (American Psychiatric Association, 1980, p. 246). New developments in and the successes of sex therapy as outlined by Masters and Johnson (1970) and Kaplan (1974) probably spurred this decision, but it was essentially an arbitrary decision. Nevertheless, once the decision was made, it has never been reconsidered seriously.

Similarly, DSM-III (American Psychiatric Association, 1980) also grouped the physical manifestations of psychiatric disorders together as Somatoform Disorders. These included Conversion Disorder and Psychogenic Pain Disorder, which respectively encompassed many of the Neuroses and the Psychophysiological Disorders of DSM-II (American Psychiatric Association, 1968), but with the “sexual” diagnoses removed from this category. For example, “. . . conversion symptoms involving sexual dysfunctions are not coded as Conversion Disorder, but rather as Psychosexual Dysfunction” (American Psychiatric Association, 1980, p. 246). Dyspareunia was the only entity removed from the Psychophysiological Disorders, renamed “Functional Dyspareunia,” and also placed in the Psychosexual Dysfunctions section.

Both Conversion Disorder and Psychogenic Pain Disorder still emphasized the psychological cause of the disorder: “. . . psychological factors are judged to be etiologically involved . . .” (American Psychiatric Association, 1980, pp. 247, 249). The Psychosexual Dysfunctions were less dependent on etiology, only excluding the

diagnosis when the dysfunction “. . . is attributed entirely to organic factors” (American Psychiatric Association, 1980, p. 275).

Currently, in the DSM-IV-TR, the diagnosis of Pain Disorder is considered a mental disorder only if “. . . psychological factors are judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain” (American Psychiatric Association, 2000, p. 499). The equivalent statement for Dyspareunia only indicates that the pain is not due exclusively to non-psychological factors. This implies that the usual apprehension, anxiety, and avoidance associated with a physiologically based pain syndrome would be supportive of a Dyspareunia diagnosis, but not a Pain Disorder. No reason is given for this disparity.

One problem with the decision to group all the sexual disorders together is that it was not complete. Psychogenic genital pain during coitus was sexual; vomiting at the thought of sex was not. Constant psychogenic genital pain, but with exacerbations associated with coitus, was not clearly addressed. Neither Psychogenic Pain Disorder nor Functional Dyspareunia are mentioned in the differential diagnosis discussion of the other, suggesting both diagnoses were possible.

With the formal separation of sexual and non-sexual diagnoses in DSM-III (American Psychiatric Association, 1980), the task of revising these diagnoses fell to different Work Groups (subcommittees). The result is that newer conceptions of one disorder may not have been reflected in the other section. Sexual disorders were understood as if they were, in essence, “sexual” and diagnostically distinct from non-sexual problems without the scientific data or even theory to support this nosology. This lack of a theoretical grounding for the division of sexual and non-sexual diagnoses may be partly responsible for the poor treatment outcome of Dyspareunia.

The DSM-IV-TR notes that “. . . each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual that is associated with present distress [e.g., a painful symptom]” (American Psychiatric Association, 2000, p. xxxi). It is tautological to define the pain as the symptom which causes pain. The diagnostic criteria for Pain Disorder avoid this pitfall by specifying the need for psychological factors which cause, exacerbate, or maintain the pain.

Another problem is the heterosexual bias in this diagnosis, as there must be “. . . genital pain with sexual intercourse” (American Psychiatric Association, 2000, p. 556). Not everyone desires coitus or is heterosexual. The focus on coitus was typical for 1980, but is revealing of continuing bias.

The DSM nosology has led to an unusual state of affairs. Dyspareunia is not a symptom of another disorder; if it were, that diagnosis would be made. Dyspareunia is not its own diagnosis, for then it would be a pain disorder. The cause does not have to be sexual, but it is a sexual diagnosis. Psychological factors are not required to have a major role in the onset, severity, exacerbation, or maintenance of the pain, but if they do, it is not considered a Pain Disorder which is defined that way. It is presumed to be a psychiatric disorder, even though many (if not most) of these individuals suffer from concomitant medical conditions. It is a disorder which only applies to sexual intercourse, psychogenic pain with other sex acts are not defined. Other non-coital sex acts which result in genital pain do not warrant a Dyspareunia diagnosis.

The present situation is reminiscent of 30 odd years ago, when psychiatry believed that homosexuality was a sexual disorder, also without empirical data. Dyspareunia is another example of a sexual disorder whose categorization was not motivated by empirical evidence; it is not consistent with the diagnostic standards presented in the DSM; it is inconsistent with the logic underlying the DSM nosology; and it has not been beneficial clinically for those who suffer from this problem. Dyspareunia is another diagnosis in the Sexual and Gender Identity Disorders section of the DSM that should be removed. Removal will not mean those previously diagnosed with Dyspareunia do not suffer from a mental disorder, only that they will now need to meet the Pain Disorder criteria.