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Peer Commentaries on Binik (2005)

The Optimal Discipline for Assessing and Managing Pain During Sex

Rosemary Basson, M.D.
Departments of Psychiatry and Obstetrics & Gynecology, B.C. Centre for Sexual Medicine, Vancouver General Hospital, Echelon 5, 855 West 12th Avenue, Vancouver, British Columbia V5Z 1M9, Canada; e-mail: sexmed@interchange.ubc.ca.

I am grateful for the opportunity to comment on three questions raised by Binik's scholarly essay. Firstly, is chronic dyspareunia an example of chronic pain or of sexual dysfunction? If it is the former, should it be assessed and managed by specialists in chronic pain? Thirdly, is the multiple etiology of chronic dyspareunia atypical of sexual dysfunction?

Is Chronic Dyspareunia an Example of Chronic Pain?

The mechanisms underlying the chronic but intermittent pain of dyspareunia are largely unknown. Mainly comprising stimulus-invoked pain (the specific stimulus being that of penile containment and its movement), chronic dyspareunia may also be associated with spontaneous pain. Examples include women with chronic pelvic pain exacerbated by intercourse and women with vulvodynia associated with localized vulvar dysesthesia, formerly known as vulvar vestibulitis syndrome. In the latter syndrome, the stimulus often is not only penile contact but contact with ejaculation fluid, with the woman's own urine, with tampon, fingers, dildo, etc. Other forms of chronic deeper dyspareunia for which the pathophysiology is quite unclear may not be replicated by other stimuli, including pelvic examination. Chronicity and (partial) response to tricyclic antidepressants and anticonvulsants support the conclusion chronic dyspareunia is an example of chronic pain. Moreover, the most common form, namely localized vulvar dysesthesia, is thought to be on the basis of neurogenic inflammation (Zolnoun, Hartmann, & Steege, 2003), as is another very common non-sexual pain, namely, migraine (Pappagalo, Szabo, Esposito, Lokesh, & Velez, 2002; Strassman, Raymond, & Burstein, 1996).

If Chronic Dyspareunia Is An Example of Chronic Pain, Should It Be Assessed and Managed by Specialists in Chronic Pain?

Despite the above, there are theoretical and practical arguments against no longer assessing and managing chronic dyspareunia as a sexual dysfunction.

1. Sexuality crosses many dimensions of human experience such that problematic sex arises from and/or affects these many dimensions. It could be argued that very few sexual dysfunctions are purely sexual entities. A recent typical morning in our sexual medicine clinic illustrated this. The first patient had the most common form of generalized erectile dysfunction (ED), namely, generalized progressive acquired ED associated with vascular impairment, known to involve endothelial dysfunction, loss of helicine arterioles, and loss of cavernosal smooth muscle. Should this be considered an example of vascular disease and be moved to the province of the internist? This first patient retained sexual desire, orgasm, and ejaculation and his mind was as sexually healthy as formerly. Similarly, the second patient, a 42-year-old woman with multiple sclerosis (MS), had acquired orgasmic disorder but with ongoing sexual desire (at least in between exacerbations of MS), ability to be subjectively sexually aroused, and no pain with any sexual acts. She has a neurological condition. Should her loss of orgasm be the province of the neurologist? My third patient, a physically well woman of 28, had low sexual interest/desire. Rarely is she subjectively sexually excited when she is sexual with her husband but she does lubricate sufficiently such that there is no discomfort or pain, i.e., she is diagnosed with the new definition "subjective arousal disorder" co-morbid with hypoactive sexual desire/interest disorder (Basson et al., 2003). Her sexual problems were long term–the whole of her sexual life save the first 6 months or so. Her history included loss of her father in a motor vehicle

accident when she was four, "loss" of her mother to her stepfather and to her new baby brother when she was seven, and loss of various friends due to multiple moves of the family during her childhood. The risk of further loss of (nonsexual) intimate relationships was huge, such that further intimacy was defended against. Sexual intimacy was thus almost impossible. I would argue that this patient's problem also was not strictly about sex but about intimacy. Sexual symptoms are extremely common. The underlying etiologies stem from multiple disciplines.

2. Chronic dyspareunia, more often than not, leads to other sexual dysfunctions in either partner, most commonly low sexual desire in women (Basson, 1998). I would suggest management of their pain with current chronic pain interventions within a sexual dysfunction framework, by a clinician trained in sexual medicine, is needed.

Is the Multiple Etiology of Chronic Dyspareunia Atypical for a Sexual Dysfunction?

Binik is concerned that the term "dyspareunia" reflects pain of many different etiologies and is thus not appropriate/typical for a sexual dysfunction. I would suggest that it is indeed typical. A familiar example would be chronic low desire/low interest reported by a woman with a 20-year loveless non-erotic marriage where sex is relegated to perfunctory intercourse once a week. A similar report of lack of desire/lack of interest (at any stage during the sexual experience) is also reported by a young woman with previously rewarding sexual experiences, subsequent to premature loss of all ovarian tissue from surgery, depriving her of some 50% of her androgen production. The major importance of acknowledging vastly different etiologies of similar sexual symptoms caused the recently convened International Committee proposing revised and expanded definitions of women's sexual dysfunction to strongly recommended the use of contextual descriptors within the diagnostic framework (Basson et al., 2003).

Conclusion

Thus, I would counter Binik's correct formulation of chronic dyspareunia as an example of chronic pain with the argument that the majority of sexual dysfunctions can be considered to be more accurately something else. However, the importance of men's and women's need for pain free and rewarding sexual experiences merits the maintenance and indeed the expansion of the disciplines of sexual medicine and sexology. These disciplines teach a sensitive, respectful, but sexually detailed interdisciplinary biopsychosocial approach. I strongly advocate keeping dyspareunia within their mandate and therefore of retaining dyspareunia as a sexual dysfunction in DSM-V.

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The "Oy" of Sex: A Medical Perspective

Jules S. Black, M.D.
2 Rae Street, Randwick, Sydney, NSW, Australia 2031; e-mail: jsblack@bigpond.net.au.

> THE SERPENT . . . You see things; and you say "Why?"
> But I dream things that never were; and I say "Why not?"
>
> George Bernard Shaw, *Back to Methuselah*, Part I, Act 1

This is bound to be a minority report coming as it does from an obstetrician/gynecologist/sexologist in most likely a sea of commentaries from psychotherapists. Even if the psychotherapists are medical, i.e., psychiatrists, their charter forbids hands-on management, thus precluding a careful vaginal examination. Since I am going to make a case for dyspareunia having a foot in both camps of psyche and soma, the fact remains no matter what is concluded by this commentary, no study of dyspareunia can be complete without a critical pelvic examination to confirm or exclude a physical component. In turn, this is why Binik's article is important. Binik has assembled a multidisciplinary team in his unit reminiscent of the heyday of Stony Brook in the 1960's and 1970's. A volume of well-respected work has already emanated from Montréal over some years, affording us the input from sexually aware gynecologists as well as psychotherapists.

Before any further discussion, I am moved to jump to the end of the article first. Binik tells us that, "As an administrator, I have also noted that it is easier to 'sell' the idea of allocating resources to pain treatment than allocating them to the treatment of sexual problems." And "as a seeker of research funding . . . new governmental funding initiatives for pain related to dyspareunia . . . this is not being matched in the sexuality area where funding is constantly under attack." If this whole exercise is merely one to facilitate funding rather than exposing a genuine need to reclassify dyspareunia in order that patients will benefit from new management models, all bets are off. I believe Binik has the latter at heart, but in the light of what I call the "female sexual dysfunction debacle," where an attempt has been made to create a new disease already covered adequately by existing terminology to facilitate research funding, permit me my cynicism. It is a statement I wanted to make from the outset.

By way of background, as a medical specialist for 34 of my 40 years since graduation, one of my mantras has been the Shaw quotation heading this review (often wrongly attributed to the late Robert Kennedy). So, upon reading Binik's article, any initial shock perceived was rapidly replaced by, "Why not?" Like Binik, I shall limit my remarks to female dyspareunia, but analogous conditions are found in males, such as *anismus* and *proctalgia fugax*. One of my pet hates is being told by a patient that previous therapists have told her either "It's all in your head" or, after a pile of tests and scans have been performed, "I can find nothing wrong with you," leading the woman to think her medical attendants believe she is imagining the symptoms. However, in fairness to my medical colleagues, there is so much to learn and this mass of material is expanding like the "big bang" over the years. So a lot of doctors feel moved to treat most ailments with either a "magic bullet" or by surgery. They haven't learned the very real therapeutic but time-consuming value of just talking to patients, that doctors themselves are just as valid a medical instrument (Balint, 1968). Since pain is the most common symptom which brings patients to see a doctor, more doctors need to learn that different patients perceive, evaluate, and act upon given symptoms differently which, in turn, make them behave in differing manners, dubbed *Illness Behavior* (IB) and *Abnormal illness Behavior* (AIB) (Pilowsky, 1978). Singh (1981) then showed us that patients may well exhibit AIB, but that it also matters what kind of doctor treats what kind of patient, and that *Abnormal Treatment Behaviour* (ATB) may be exhibited. Then came concepts of somatization (e.g. Ford, 1986; Lipowski, 1987), and then an extension of IB and AIB, Pain Behavior (Tyrer, 1986). The consciousness of gynecologists regarding their responsibilities towards patients' sexual difficulties needs to be raised. After all, no sexuality, no obstetrics and gynecology (Black, 1974)!

An inevitable interest in psychosomatic obstetrics and gynecology started 30 years ago, and I absorbed these concepts well known to psychotherapists, but absent from our mainstream specialist medical literature. I have come to learn that the word "pain" is a form of "currency" used by patients to mean various things, but above all, it is a cry for some sort of help. Each of our medical specialties, of necessity representing a narrower band of medical knowledge hived off from the entire medical "cake," has its own "currency" to describe pain syndromes within that specialty. Such "currencies" include fibromyalgia, chronic fatigue syndrome, irritable bowel or bladder syndromes, muscular and migraine headaches, premenstrual syndrome, chronic pelvic pain, or finally–vulvodynia.

Whereas Binik's case to redefine the term dyspareunia and to reclassify sexual dysfunctions as a result is absolutely fair, the various forms of dyspareunia definitely will not completely sit well in either a revised DSM or ICD. As I already hinted, there is a foot in both camps, an interface. Binik chooses to exclude vaginismus from his discussion, I really know not why, and I am moved to touch upon it briefly. Vaginismus is vaunted as *the* classical example of a psychosomatic condition. The psyche is willing, used to be willing or maybe wasn't ever willing, but the soma is saying a definite "No"! We have the chicken or egg situation here. Has the fear of penetration/pain/mutilation led to this condition or have painful, unsuccessful attempts at intercourse led to the involuntary pain behaviour and apareunia? Later on, Binik cites an increased degree of marital distress in vulvar vestibulitis syndrome (VVS). Again, what came first? Vaginismus will never fit in the ICD. Separately, lack of sexual arousal and its sequelae are a potent cause of introital dyspareunia plus the pelvic congestion syndrome experienced some hours later. I have always held the view, based on long experience with very positive outcomes, that whereas the patient may say, "Doctor, I don't enjoy sex because it hurts," I respond, "Au contraire, sex hurts because you don't enjoy it" (Black, 1991). When Binik cites the classical words, "Not tonight dear, I have a headache," of course this is not dyspareunic pain, but it is a "currency" or code, a subtext.

Turning to specifics, Binik and his team are bringing us groundbreaking research in qualifying and quantifying genital pain scientifically for the first time. I agree wholeheartedly that there are not two types of pain in the body viz. sexual and non-sexual pain, but we have tended to think as if there were. His group's finding of touch thresholds being significantly lower in VVS subjects exemplifies AIB, i.e., what kind of patient is having the pain? Special situations he cites such as firstly the woman who experiences the pain of subsequent dyspareunia *prior* to her first "sexual experience" (intercourse?) will very likely be describing the Pelvic Congestion Syndrome (PCS), the female equivalent of "blue" or "lover's balls." Secondly, the woman who experiences the pain of VVS years after painful adolescent tampon experiences will very likely be describing underlying suboptimal perineal hygiene ± secondary vaginismus (Black, 1988). Even Pagano (1999) associated chronic moniliasis with VVS. However, I contend that if a woman is penetrated when incompletely aroused, the physiological self-opening and self-lubricating mechanisms of the vagina and vulva are not activated. Such forceful entry of an unwelcoming, dry, narrow orifice will cause mini-abrasions around the introitus. They will take some 36–48 hours to heal over. In the interim, every time urine is passed, her nerve endings will smart since the urine is both acidic and at deep

body temperature (Black, 2000). The quoted prevalence of VVS as being approximately 12% strikes me as high and certainly 12% of sexually active women do not have symptoms of VVS. I listen in awe when Binik cites a ≈70% reduction in VVS pain after vestibulectomy. I have discussed this with him, and still await comparable results from other units.

Most of the dyspareunias described represent a dynamic situation, in that is there is penile thrusting causing pain at the introitus or deep within the pelvis where pelvic organs are being displaced, squeezed or ligaments pulled. The non-dynamic situations where sex-related pains are experienced are the orgasmic dysfunctions including preorgasmia, PCS sometimes long after intercourse, colpalgia fugax, and VVS, which can linger on for days. Where Binik cites a lack of clarity in interpretations within DSM-III and DSM-IV-TR, at least some of the editors of either volume must still be alive, why not ask them? Binik notes there has never been a randomized controlled treatment outcome study for dyspareunia. So, what are we going to do? Have one group incapable of or forbidden to climax versus controls? Easier said than done.

As we become more aware of pain behaviors and, in turn, of more effective pain management, various textbooks will have to be rewritten. This will take a long time from now before such new concepts and treatment modalities percolate down the line to young doctors and psychologists. It is clear that special doctors, not all doctors, will need to be more aware of patients' sexual difficulties in the same way you cannot expect all psychotherapists to be comfortable with managing sexual dysfunctions. It is also patently clear that neither psychologists nor doctors have all the answers. Together we will get somewhere. I know from my own management of vaginismus over 36 years, many still apareunic women have come referred to me via psychiatrists and psychologists and I have been successful in helping them achieve not only intercourse, but to accept their vagina as a normal organ and to enable women to insert creams, tampons, etc., as any "normal" woman can. Women presenting with sexual pain syndromes must have a critical pelvic examination somewhere along the line.

I cannot see all of the sexual pain syndromes ever being reclassified and shifted over to the ICD. There are distinct psychological and somatic components in most of the problems. If it comes to pass that a shift happens, I make a plea that medical educators and textbook authors add some novel integrative tables into their teaching. In other words, in the same way we are taught perspectives such as the ocular, cutaneous or arthritic manifestations of disease, I believe we should see new tables devoted to the sexual consequences of systemic disease. Finally, if this whole exercise is merely one to facilitate funding rather than exposing a genuine need to reclassify dyspareunia in order that patients will benefit from new management models, all bets are off.

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Reclassification Will Not Make the Pain Go Away

Kristen M. Carpenter, M.A., and
Barbara L. Andersen, Ph.D.
Department of Psychology, Ohio State University, 1885 Neil Ave., Columbus, Ohio 43210; e-mail: Andersen.1@osu.edu.

Binik addresses several previously unexplored questions about the clinical problem of dyspareunia and offers data from his own research to help clarify its clinical characteristics. His most provocative comments, however, come with the suggestion to change the DSM classification of the disorder to one of urogenital pain rather than sexual dysfunction. We applaud Binik's attention to this understudied and commonly misunderstood condition and the impetus it has provided to the scientific community to respond to his suggestion. Here, we provide a brief response to the general messages of the article. Ultimately, however, we make the case that reclassification would not aid in the diagnosis or treatment of dyspareunia. In doing so, we will offer the following perspectives: (1) We found the literature review unnecessarily limited in focus, with important work comparing dyspareunia to other types of sexual dysfunction omitted; (2) Binik's own data, while interesting, represents only a subgroup of the heterogeneous population of dyspareunia patients; (3) the closing arguments regarding advances to be gained with the treatment of dyspareunia by pain specialists are of clinical interest, although they are peripheral to the central question of classification.

Binik likens dyspareunia to pain syndromes and his research with patients suffering from vulvar vestibulitis (VV) provides the basis for several arguments. VV patients accounted for 46% of the cases in Meana, Binik, Khalifé, and Cohen (1997) and 100% in Pukall, Binik, Khalifé, Amsel, and Abbott (2002). VV accounts for a small (albeit unknown) portion of all dyspareunia cases. As such, it is a population and body of research with unknown generalizability to all dyspareunia cases. The Meana et al. (1997a) and Pukall et al. (2002) data suggest commonalities of dyspareunia and VV with pain disorders, as would be predicted. The data do not, however, prove that dyspareunia is only (or even predominantly) consistent with pain disorders rather sexual disorders.

Binik asserts that there is little justification for continuing to classify dyspareunia as a sexual dysfunction. Following the discussion of the similarity of dyspareunia and pain disorders, the "flip side" argument for Binik would have been a presentation of data showing the *dissimilarity* of dyspareunia sufferers with individuals with other sexual disorders. In fact, there are many data suggesting the opposite, i.e., the similarity of dyspareunia patients to other sexual dysfunction cases. For example, Laumann, Paik, and Rosen (2001) conducted multinomial logistic regression analyses to identify psychosocial and medical risk factors for a number of sexual disorders using data from the population based sample in the National Health and Social Life Survey. Among others, two findings are of relevance to this discussion. First, when modeled statistically, "sexual pain disorders" emerged as a distinct latent construct, related though separate from other sexual disorders. Second, similarity in risk factors for dyspareunia and other sexual difficulties were found. For example, women experiencing urinary tract infection were at increased risk for sexual pain and also impaired sexual arousal. Women reporting substantial change (decrease) in annual household income during the previous four years reported sexual pain as well as inhibited sexual desire. Finally, emotional problems/stress increased risk for *all* sexual dysfunctions, not only or not to the exclusion of dyspareunia. Results are similar for decrements in quality of life.

Binik correctly notes that desire, arousal, and orgasm are diagnosed by their interference in the underlying physiologic processes without reference to a specific behavior (e.g., sexual intercourse). We agree and note further that the behavior of intercourse is relevant to the diagnosis of dyspareunia. We add, however, that inclusion of intercourse may be unnecessarily limiting, as some women can report pain with sexual touching or the anticipation of sexual events (Binik, Bergeron, & Khalifé, 2000; Heiman, 1995). Still, the inclusion of intercourse is important and is pathogenic for many patients (see Schover, 1995).

Experimental data also demonstrate the importance of this behavior for women with dyspareunia. Wouda et al. (1998) compared sexual responsiveness in 18 women with dyspareunia to 16 healthy controls using a vaginal plethysmograph and self-report measures of arousal. Readings were taken at rest and during three video segments depicting primarily oral sexual activities, cunnilingus only, and coitus. Vaginal plethysmograph readings for the two groups were equivalent for the oral segments but significantly differed for regments depicting coitus. As predicted, women with dyspareunia showed decreased vasocongestion, even though their subjective reports of arousal were equivalent to those of women without sexual dysfunction. These data suggest disruption in sexual response does occur for dyspareunia patients (as it does with other types of sexual dysfunction) and provide general support for the diagnostic utility of including interference with intercourse as one marker of dyspareunia. These data are illustrative of other literature providing support for the similarity of dyspareunia with other sexual dysfunction diagnoses (Laumann et al., 2001).

Binik correctly notes the symptom overlap in the DSM description of dyspareunia and pain disorders. We would add that overlap among DSM diagnoses is common and, of course, problematic (see Widiger & Clark, 2000 for a discussion of DSM nosology). Several examples can be cited. A variety of disorders share overlapping symptoms, including childhood mania, attention deficit hyperactivity disorder, and conduct disorder (Kim & Miklowitz, 2002); PTSD and major depressive disorder (Franklin & Zimmerman, 2001); and autism and schizophrenia (Konstantareas & Hewitt, 2001). Some argue that PTSD should be classified as a dissociative rather than anxiety disorder (for a review see Brett, 1996). Unlike Binik, we do not agree that the overlap suggests that one diagnosis (pain) is better suited than another (sexual dysfunction) for dyspareunia. Alternatively, what overlap *does* guarantee is the unreliability of many diagnostic decisions, including those for dyspareunia.

Binik goes on to suggest that reclassification of dyspareunia as a pain syndrome would, necessarily, result in a paradigm shift such that pain specialists would become the discipline guiding any treatment team. He makes the observation that with the current classification of dyspareunia the involvement of pain specialists is rare. He suggests that the more typical scenario is one of guidance by gynecologists and mental health professionals, who, in Binik's view, have "taken little interest" in dyspareunia. If pain specialists are not currently involved in treating dyspareunia (and there is no empirical evidence to indicate this is or is not the case), the inclusion of pain specialists is not an issue to be remedied by reclassification, but by education for professionals that emphasizes multidisciplinary treatment and alteration by professionals of referral and consultation patterns. The development and dissemination of practice standards for treatment would also be important and would provide another mechanism to underscore the necessity of multidisciplinary treatment (see Basson [2002] and Graziottin [2001] for relevant discussions of assessment and treatment of sexual pain).

We note that the biopsychosocial approach aimed at pain control, illness reduction, and sex promotion, already occurs but, unfortunately, it may not be widespread. Heiman (1995), for example, provided a case example

of collaboration of pain specialists and sex therapists for a woman with complaints of dyspareunia and fibromyalgia. Similarly, Schover (1995) described a case of a woman receiving combined sex therapy and vulvar surgery for chronic dyspareunia. Some treatment centers currently offering state of the art treatment of sexual dysfunction do so with a multidisciplinary staff (e.g., Institute for Sexual Medicine at Boston University Medical School; Female Sexual Medicine Center at UCLA). Such centers include specialists from urology, gynecology, psychology, nursing, and radiology, with endocrinologists, neurologists, and others serving as consultants. We applaud Binik's discussion of needed efforts for comprehensive treatment for dyspareunia patients, but the absence of comprehensive treatment is likely not a problem caused or remedied by DSM classification (Widinger & Clark, 2000).

In summary, Binik and colleagues have advanced our clinical understanding of dyspareunia and offer compelling arguments regarding the unmet needs of patients. VV patients represent one subgroup of the population, and additional research is needed to identify other subgroups. In short, clarification of the clinical diversity that can be found among all patients diagnosed with dyspareunia is needed. We offer that the classification of dyspareunia as a sexual disorder, flawed as it may be, is the diagnostic category with the greatest clinical utility at present.

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Dyspareunia and DSM: A Gynecologist's Opinion

Graeme Dennerstein, M.D.
Department of Obstetrics and Gynecology, Dermogynaecology Clinic, Mercy Hospital for Women, University of Melbourne, 111 Rose Street Essendon, Victoria 3040, Australia; e-mail: gragrazdenn@smartchat.net.au.

Binik is correct in questioning the wisdom of the use of the term "dyspareunia" in DSM. As a gynecologist with a long-standing special interest in vulvovaginal clinical pathology, I would have thought that the term was out of place in a classification of psychiatric diagnoses. Essentially, the arguments are about semantics. "Dyspareunia" is nothing more than a symptom. It is the symptom of a large number of disease states which can arise from infections, other inflammatory disorders, congenital and neoplastic disorders, altered hormonal states as well as psychologically mediated disorders of function. It is not clear to me what DSM-IV is referring to under "Dyspareunia (Not Due to a General Medical Condition)"—possibly dysesthesia.

Difficult or painful intercourse (dyspareunia) is certainly common in the community (Marin, King, Dennerstein, & Sfameni, 1998) and is acknowledged as such by the undergraduate and postgraduate courses with which I have been associated. For example, it receives appropriate attention in an undergraduate text to which I recently contributed (O'Connor & Kovacs, 2003).

Vulvar vestibulitis syndrome remains the subject of much debate (Marin & Dennerstein, 2002; Sackett & Galask, 2002) and its inclusion in this discussion is bound to muddy the waters. In contrast to Binik, my prediction for vulvar vestibulitis syndrome (Dennerstein & Scurry, 1999) is that it is destined for the dustbin of the diagnostically destitute. As with other comparable syndromes in this area (leucorrhoea, non-specific vaginitis, leukoplakia, etc.), improved clinical and laboratory investigation will elucidate the multiple disease processes responsible so that we shall not continue to confuse symptoms with diagnoses.

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Is Dyspareunia Unrelated to Early Sexual Abuse?

Michael P. Dunne, Ph.D., and Jake M. Najman, Ph.D.
School of Public Health, Queensland University of Technology, Kelvin Grove, Queensland 4059, Australia; School of Population Health, The University of Queensland, Herston Road, Herston, Queensland, Australia; e-mail: m.dunne@qut.edu.au.

The question of whether psychosocial correlates of dyspareunia are more relevant to pain syndromes or to sexual dysfunction is complex and deserves a deeper consideration than is offered by Binik. The fundamental issue is whether we can show that potentially pathogenic life experiences and social conditions are specific to, or separable from, sexual difficulties, pain or, indeed, any of the common chronic disorders.

Child sexual abuse (CSA) is possibly the most frequently studied psychosocial insult to be linked with health problems in adults. Binik stated that sexual abuse is thought to interfere with sexual function, but has not been shown to correlate with dyspareunia; however, he did not consider observations of significant associations between CSA and self-reported dyspareunia (Golding, 1994; Walker et al., 1999) and the broader categories of genital/pelvic pain in women that may include dyspareunia (Finestone et al., 2000; Green, Flowe-Valencia, Rosenblum, & Tait, 1999; Hulme, 2000; Lampe et al., 2003). Although Binik and colleagues and some other researchers (e.g., Bornstein, Zarfati, Goldik, & Abramovici, 1999; Edgardh & Abdelnoor, 2003; Romans, Belaise, Martin, Morris, & Raffi, 2002) do not find an association between dyspareunia and sexual maltreatment, a more

appropriate conclusion is that the correlational patterns are conflicting rather than clear-cut.

Of course, CSA is linked with a plethora of psychological and physical disorders. In addition to a wide spectrum of mental health problems (Fergusson & Mullen, 1999), various clinical and population-based studies find CSA to be associated with physical disorders as diverse as diabetes, heart disease, arthritis, asthma, and non-epileptic attack disorder (Golding, 1994; Reilly, Baker, Rhodes, & Salmon, 1999; Romans et al., 2002). Some of these linkages are biologically or psychopathologically plausible; others are not. Unfortunately, much of the data are clouded by potential biases in recall of the sometimes distant experiences and the context surrounding them. If this occurs during interviews about general health or chronic diseases that do not have an overtly sexual dimension, then how much more likely is recall bias when we take sexual histories of women living with dyspareunia?

If we focus on the broad category of chronic pain disorders, it is also difficult to find clear evidence for or against an association with psychosocial factors, including sexual abuse. For example, there is current argument about links between CSA and chronic low back pain (Linton, 1997; Nickel, Egle, & Hardt, 2002). Prevalence of pain in most major body sites has been found to be high among women who report a history of such abuse (Green et al., 1999; Hulme, 2000; Walker et al., 1999). Others find little or no association with general body pain, including fibromyalgia (Raphael, Widom, & Lange, 2001; Taylor, Trotter, & Csuka, 1995). The answer is unlikely to become clearer through uncritical comparison of lists of published papers that find evidence either way, given that the studies involve different clinical samples, research designs, and measurements.

Binik's thesis is helped by findings from an elegant, prospective study by Raphael et al. (2001), in which known victims of CSA were followed into adulthood and assessed for pain complaints. There were no significant associations between objectively determined abuse history and five measures of pain symptoms and pain-related illness. Although pain during intercourse was not specifically assessed, Raphael et al. offer the most convincing evidence to date that CSA does not precede pain disorders and question whether "medically unexplained" pain should be thought to have psychological origins.

Sexual dysfunction is heterogeneous. Some manifestations are primarily psychological, such as poor sexual self-esteem, lack of interest, anxiety or depression during sexual activity, and a general inability to find sex pleasurable. Common physical characteristics include persistent infection, vaginal dryness, and excessive tenderness. The origins of severe genital pain are complex, but might most plausibly be related to physical causes (Bornstein et al., 1999).

As Binik pointed out, little research has examined the extent to which psychosocial or physical factors might explain variation in subtypes of sexual dysfunction. In a small community survey, Schloredt and Heiman (2003) found that women sexually and/or physically abused during childhood did not differ from others in relation to sexual pain, difficulties in arousal and achieving orgasm, and sexual desire; however, those with a history of CSA had significantly more negative perceptions about their sexuality and more negative mood during sexual arousal.

This question stimulated further analysis of data from a recent telephone-based survey of a randomly selected national sample of the Australian adult population (aged 18-59 years). In separate papers, we have reported data on child sexual abuse (Dunne, Purdie, Cook, Boyle, & Najman, 2003) and sexual dysfunction (Najman, Dunne, Boyle, Cook, & Purdie, 2003), but have not yet reported relationships between these two variables.

The survey methods have been described in detail by Purdie, Dunne, Boyle, Cook, and Najman (2002). Volunteers answered questions about a wide range of health and sexual issues. Our questions on sexual dysfunction were adapted from a study by Laumann, Paik, and Rosen (1999) and included one item specifically asking about experiences of persistent physical pain during intercourse for several months or more during the preceding year and, for women, six other questions about sexual dysfunction. Prevalence estimates were quite similar to those reported by Laumann et al. for a similarly-aged national sample in the United States (Najman et al., 2003). There were nine questions about a range of unwanted sexual experiences prior to the age of 16 years. The prevalence of attempted or completed penetrative CSA (combined oral, vaginal, anal) among females was 12.2% (Dunne et al., 2003).

Associations between history of penetrative CSA and the measures of sexual dysfunction are shown in Table I. We compared women who reported a history of penetrative abuse with other women because this particular experience is most strongly associated with adverse health outcomes (Bulik, Prescott, & Kendler, 2001; Fergusson & Mullen, 1999). The analysis is based on data from 771 women who were not virgins and who answered all questions about CSA and sexual dysfunction. The findings offer some support for the dissociation that would be predicted by Binik. That is, CSA was significantly associated with higher prevalence of anorgasmia, "finding sex not pleasurable," and anxiety over performance. It was not significantly associated with persistent pain during intercourse and difficulty in becoming lubricated. One common psychological problem (lack of interest in sex)

Table I. Penetrative Childhood Sexual Abuse (CSA) and Symptoms of Sexual Dysfunction among Women

Symptom	Penetrative CSA category			
	No (%)	Yes (%)	Odds ratio	95% CI
Lack of interest in sex	32.9	41.4	1.37	0.95–1.99
Unable to achieve orgasm	18.6	31.3	1.80	1.22–2.65
Reach orgasm too quickly	9.0	12.1	1.32	0.76–2.30
Physical pain during intercourse	15.8	23.2	1.51	0.98–2.31
Not find sex pleasurable	17.4	30.3	1.85	1.25–2.73
Anxious about performance	11.9	21.2	1.79	1.16–2.76
Trouble becoming lubricated	20.5	24.2	1.20	0.79–1.84

Note: Item wording was "During the past 12 months, has there been a period of several months or more when you . . . "

was not associated with CSA and a rarer difficulty for women (reaching orgasm too quickly) was also not associated with CSA history.

One interpretation of these data is that early sexual trauma affects the primarily psychological aspects of sexual dysfunction. In contrast, persistent pain during intercourse and difficulty achieving lubrication could be considered as primarily physical manifestations. These data are only indicative and the differences in odds ratios across the various aspects of sexual dysfunction were not very large. Overall though, there is some suggestion that pain during intercourse might be differentiated from sexual dysfunction by this potent psychosocial variable.

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Weighing the Pro's and Con's of Reclassifying Dyspareunia

Michael B. First, M.D.
Biometrics Research Department, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 60, New York, New York 10032; e-mail: mbf2@columbia.edu.

Binik claims that the definition and diagnostic criteria for dyspareunia "make little sense and should be scrapped" and argues that "on both empirical and theoretical grounds," the current category "be discarded," that is, removed from the sexual disorders section of DSM-IV-TR and reclassified as a "urogenital pain disorder" in the Somatoform Disorders section.

Making such a radical change to the DSM-IV-TR, such as eliminating a category, should require a high threshold of empirical evidence–the evidence presented by Binik is far from convincing. Changes to the DSM-IV-TR involving the addition or deletion of categories require a careful analysis of its potential advantages and disadvantages. Although Binik purports that reclassifying dyspareunia will have certain advantages (which I review and question below), Binik ignores any consideration of the potential disadvantages.

The main organizational principle behind grouping disorders together within major diagnostic groupings in the DSM is "descriptive and pragmatic . . . rather than on an empirical foundation or theory about pathogenesis" (Phillips, Price, Greenberg, & Rasmussen, 2003). Most commonly, the overriding goal is to group together disorders that share a presenting symptom in order to encourage appropriate differential diagnosis (e.g., mood disorders are grouped together into a single diagnostic class in order to facilitate the differential diagnosis of depressed, elevated, or irritable mood). In other cases, disorders are grouped together because of clinical utility (e.g., somatoform disorders are grouped together because of the need to exclude an occult general medical condition as the etiology for the bodily symptoms) or in order to facilitate lookup by mental health professionals working in a particular setting (e.g., grouping together disorders first diagnosed in infancy, childhood, or adolescence).

Thus, whether or not dyspareunia should be classified as a sexual disorder or a pain disorder in the DSM-IV-TR should depend on whether it is more clinically useful for dyspareunia to remain a separate category in the sexual disorder section of DSM-IV-TR or to be folded into the pain disorders category in the Somatoform Disorders section. (First et al., 2004; Kendell & Jablensky, 2003). Binik's claim that the pain in dyspareunia is similar to other pain is not particularly persuasive since it is well established that particular psychiatric symptoms are not diagnostic of any disorder and that the same psychiatric symptoms occur across many different disorders and across different diagnostic groupings. For example, Pope and Lipinski (1978) demonstrated that the so-called first rank symptoms of schizophrenia (e.g., thought insertion), which were thought to be diagnostic of schizophrenia,

appear in both schizophrenia and mania, disorders included within different diagnostic groupings of the DSM.

Furthermore, virtually all of the empirical data cited by Binik (i.e., sensory testing, brain mapping, physical and psychosocial correlates, treatment response) are confined to women suffering from vulvar vestibulitis syndrome (VVS), since it "provided an easily localized type of pain which could be conveniently measured in the laboratory." However, according to the current DSM-IV-TR definition of dyspareunia, rather than being considered a subtype of dyspareunia (as Binik does), women with VVS do not meet criteria for dyspareunia but instead are considered to have a Pain Disorder. In particular, the criteria for dyspareunia exclude a diagnosis of dyspareunia if the pain during intercourse is exclusively due to a general medical condition. VVS is considered to be an "inflammatory disease of the cervix, vagina, and vulva," and has been assigned a diagnostic code of 616.10 in the ICD-9-CM (the classification of general medical conditions used by all health care professionals in the United States). Thus, almost all of the cited studies are irrelevant in terms of supporting an argument that dyspareunia is a pain disorder since these women are not considered to have dyspareunia!

The main purported advantage cited by Binik, from a clinical utility perspective, of folding dyspareunia into the DSM-IV-TR pain disorders is in the area of treatment. Binik claims that "conceptualizing dyspareunia as a sexual dysfunction limits the range of treatments to be considered to different psychotherapies directed at the sexual problem or to medical/surgical interventions directed at the underlying pathology" and that "pain, as opposed to sex-oriented therapies, are the starting point for treatment of dyspareunia." However, Binik notes that "there are no empirically validated treatments for dyspareunia." Thus, it remains an empirically open question whether treatments taken from the traditional armamentarium of pain control are superior to behavioral or psychological interventions– it is likely that a multidisciplinary approach may be the most appropriate. In fact, as Binik notes, "even if pain is diminished, then there is still an important need for intervention to promote sexuality," arguing for the continued relevance of sex therapy in the treatment of dyspareunia. In any case, why should its current placement in the "sexual pain disorders" section of DSM prevent the application of pain approaches to its treatment?

Binik also claims additional practical reasons for eliminating dyspareunia as a sexual disorder, including improving the therapeutic alliance with their patients by encouraging clinicians to focus more on the pain. Why not simply educate clinicians about the importance of focusing on the pain? In any case, how would reclassifying dyspareunia from a "sexual pain disorder" (as it is now) to a pain disorder in the Somatoform Disorder section lead to a shift in the focus on pain? Binik also expresses hope that the reclassification will result in a greater allocation of treatment resources and increased research interest and funding opportunities. As a matter of policy, DSM decisions are never based on reimbursement or research funding issues, largely because these problems are almost never related to the classification itself but instead represent more fundamental issues (such as stigmatization) which would not be rectified by superficial tinkering with the DSM.

Binik's proposal to reclassify dyspareunia does have some potential disadvantages that he fails to consider. First, I should clarify precisely what his proposal entails on a practical level. Under Binik's proposal, dyspareunia, which is now assigned the diagnostic code of 302.76, would be eliminated and instead the clinician would make a diagnosis of a Pain Disorder. If psychological factors are judged to have the major role in the onset, severity, exacerbation or maintenance of the pain, then the diagnosis of "Pain Disorder Associated with Psychological Factors" is made and a code of 307.80 is assigned. If both psychological factors and a general medical condition are judged to have an important role in the pain, then "Pain Disorder Associated with Both Psychological Factors and a General Medical Condition" is diagnosed and two codes are given: 307.89 on Axis I and the code for the general medical condition or anatomical site of the pain on Axis III (e.g., 616.10 for VVS). If no psychological factors are involved, then only the general medical condition or anatomical site is coded (on Axis III). Thus, under Binik's proposal, the unique diagnostic code for dyspareunia would be lost, potentially inhibiting record keeping and the specificity of diagnostic reporting, since there would be no way to differentiate between dyspareunia and other pain disorders associated with psychological factors. Furthermore, by removing dyspareunia from the sexual disorders section, it may potentially reduce the likelihood that other co-morbid sexual dysfunctions will be diagnosed and treated, which, as Binik's own data suggest, are still relevant problems in this population.

I do applaud the attention that Binik's article brings to this relatively neglected category in the DSM. For example, during the literature review phase of the DSM-IV revision process, the only issue considered by the Sexual Disorders Workgroup was whether to reinstate the DSM-III exclusion criterion that had been removed in DSM-III-R (Schiavi, 1996). Binik does point out important problems with the category. For example, labeling dyspareunia a sexual dysfunction is confusing since the DSM text defines sexual dysfunctions in terms of a dysfunction in one of the various phases of the

sexual response cycle (i.e., desire, arousal, orgasm) and dyspareunia is not linked to any particular phase of the cycle. Furthermore, although dyspareunia is defined in terms of genital pain associated with sexual intercourse, the lack of clarity regarding whether the pain occurs in other situations makes the boundaries of this disorder potentially confusing. His article provides a useful starting point for the literature review process that will undoubtedly set the stage for the DSM-V deliberations.

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Why Deny Dyspareunia Its Sexual Meaning?

Alessandra Graziottin, M.D.
Center of Gynecology and Medical Sexology, H. San Raffaele Resnati, Via Enrico Panzacchi 6, 20123 Milano, Italy; e-mail: segreteria@studiograziottin.it.

The thought-provoking and well-argued article of Binik is challenging. His proposal to reconceptualize the heterogeneous group of coital pains as "urogenital (sexual) pain disorders" would have been worthy of attention for a nosological change had he not proposed to delete the key word "sexual."

Dyspareunia indicates the urogenital pain caused by intercourse. This is a specific, but not unique, triggering factor. Coital pain interferes with intercourse, as Binik states, but it is caused by it as well. Urogenital pain, on the other hand, may be caused by many other factors. Dyspareunia is, indeed, a sexual dysfunction with a multifactorial and multisystemic etiology (Graziottin, 2001, 2003a, 2003b, 2003c; Graziottin, Nicolosi, & Caliari, 2001a). Predisposing, precipitating, and maintaining factors, both psychosexual and biological (muscular, endocrine, immune, neurologic, vascular, iatrogenic) may variably interact in the individual woman contributing to a continuum of symptoms of increasing severity and potential for impairment. The key pathophysiological factors involved in dyspareunia may change over time, when the persistence of unaddressed causal factors upregulates the immune and pain systems (Bohm-Starke, Hilliges, Blomgren, Falconer, & Rylander, 1999; Bohm-Starke, Hilliges, Blomgren, Falconer, & Rylander, 2001; Bohm-Starke, Hilliges, Brodda-Jansen, Rylander, & Torebjork, 2001; Graziottin & Brotto, 2004). This is why from the medical and pathophysiological point of view Binik's reasoning has some weaknesses that contradict his proposal.

First, Binik does not consider the concept of the natural history of dyspareunia. He discusses different clinical situations, with no comment on the key parameter of time from onset of the symptom. Time is not simply a sterile chronological concept, but the influencing witness of the complex changes that pathophysiological factors undergo when chronic tissue damage is in play. This change does not modify the category of the disorder (a cancer remains a cancer even if it is complicated by unbearable pain and does not become "a pain disorder" even if it requires specific multimodal anthalgic treatment). If we look at the natural history of a disease or a disorder like a movie, it is easy to understand that the moment of the clinical diagnosis is equivalent to focus on a single frame in a movie. The protagonist(s) we will encounter can change as the story unfolds over time. The natural history of disease is no exception. Unfortunately, all of Binik's argument on dyspareunia focuses only on the final picture of a very specific cause of introital pain, i.e., vulvar vestibulitis (VV), dismissing the many other types of superficial, mid-vaginal, and deep dyspareunia. He stresses that VV and related vestibular pain may be present before the first intercourse. This is true but does not disqualify dyspareunia as a sexual disorder. It simply means that from a life-span perspective, a chronic inflammation of the introital mucosa leading to neuropathic pain may be triggered by a heterogeneous set of damaging factors. Urine leakage in enuretic children and adolescents may cause VV before the very first intercourse (Chiozza & Graziottin, in press). Indeed, VV may be pre-existing, concomitant or consequent to intercourse, which may worsen the mucosal damage through the mechanical trauma it provokes when dry mucosa in a non-aroused condition and/or a tightened pelvic floor increase the introital vulnerability. Binik does not seem to consider (or at least does not mention in his paper) the key difference between "nociceptive pain" that is present at the beginning of dyspareunia's natural history (when the etiology is other than pre-existing VV) and "neuropathic pain" that may be present when months and years of repetitive mucosal damage have occurred, i.e., late in the natural history of this disorder (Baron, Levine, & Fields, 1999; Baron, Schattssneider, Binder, Siebrect, & Wasner, 2002; Bonica, 1990; Vincenti & Graziottin, in press). Nociceptive pain indicates ongoing damage caused by coitus, from which the woman might try to withdraw to protect herself from further damage and pain. It is a symptom of very different etiologic factors that are causing dyspareunia. Neuropathic pain becomes independent from the initial predisposing and precipitating coital trauma or inflammatory event. It is generated within the pain system and becomes a disease per se (Graziottin & Brotto, 2004; Graziottin & Vincenti, 2002; Vincenti & Graziottin, in press). At this point of the natural history, pain may become spontaneous or associated with non-coital events, like biking, having finger foreplay, wearing

tight jeans or a tampon. This late change is typical of VV, to which much excellent research of Binik is devoted (Bergeron, Binik, Khalifé, & Pagidas, 1997; Bergeron et al., 2001; Pukall, Binik, Khalifé, Amsel, & Abbott, 2002; Pukall, Strigo, Binik, Khalifé, & Bushnell, 2003; Meana, Binik, Khalifé, & Cohen, 1997). Indeed, after months or years of persistent inflammation and pain, the anatomical and biochemical tissue picture may shift from a reactive situation to a microtraumatic event to a self-maintained chronic inflammation with an upregulated pain system.

This shift to neuropathic pain is neither constant nor typical (dyspareunia caused by etiologies different from VV rarely has neuropathic characteristics). The shift may depend on the plasticity (neuroplasticity and psychoplasticity) of the pain system, on the persistence of damaging factors (including coitus without genital arousal on vulnerable mucosa), and/or on the individual vulnerability of the immune and pain systems themselves in a subset of women affected by VV. This may support the final inclusion of VV-related pain in chronic pain disorders, as it shares features in common with other chronic pelvic pains; however, this neuropathic outcome cannot and should not be generalized to all types of dyspareunia.

In particular, this generalization should be avoided when lifelong, introital dyspareunia may be caused by vaginismus, not severe enough to prevent penetration but sufficient to cause genital arousal disorder and coital pain. Without intercourse or other attempts at vaginal penetration (like the gynecological examination, which symbolically may mimic what is most feared, i.e., intercourse), there is no pain. In contradiction to previous research, severe vaginismus has been recently shown to be characterized by abnormally increased basal tonic activity of the levator ani muscle, associated with a lack of or reduced ability to inhibit it with straining (Graziottin, Bottanelli, & Bertolasi, in press).

Contradicting what Binik says, dyspareunia does interfere with other dimensions of sexual function: Unwanted pain is the strongest reflex inhibitor of genital arousal, thus causing or contributing to vaginal dryness. This increases the vulnerability of the introital mucosa to coital mechanical trauma. It may also cause secondary loss of sexual desire and central arousal, with further orgasmic difficulties. Indeed, in my series of patients suffering from dyspareunia caused by VV, 58.1% reported acquired desire disorders, 50% acquired arousal disorders, and 40.3% acquired coital orgasmic difficulties (Graziottin, Caliari, & Nicolosi, 2001b). The resulting acquired sexual co-morbidity further complicates the clinical picture from the psychosexual point of view.

Second, Binik uses the terms VV and dyspareunia interchangeably; however, VV is a heterogeneous condition that is the leading cause of dyspareunia in the fertile age (Friedrich, 1987; Graziottin, 2001, 2003a) but cannot be used as synonymous for or assimilated to it. This is confusing. All the arguments Binik used in support of his thesis are based on research into VV. However, dyspareunia may be caused by factors very different than VV. For example, the majority of postmenopausal dyspareunia cases are associated and co-morbid with genital arousal disorders related to the hypoestrogenic condition. It is unusual for these cases to evolve into neuropathic pain, unless it was formerly present and reactivated by topical estrogenic treatment (Graziottin, 2003b, 2003c).

Third, chronic VV (but not dyspareunia) may be considered a typical pain syndrome, like Interstitial Cystitis (IC), two conditions with an impressive sharing of pathophysiology (Tarr, Selo-Ojeme, & Onwude, 2003). Among the key factors, the upregulation of mastcells with production of nerve growth factors, which induces the proliferation of pain fibers; the neurogenically mediated inflammation backwards to the sensory nerves; the recruitment of silent pain fibers, the "cross-talk" between nerves sharing the same tissue innervation in neighbouring organs (like bladder and vestibule); and the lowering of the central pain threshold (Tarr et al., 2003). Last, but not least, there is the average diagnostic delay, up to 4.8 years for VV (Graziottin, Nicolosi, & Caliari, 2001a) and 4 to 7 years for IC.

Fourth, Binik assumes that different etiologies of either introital or deep coital pain argue against the appropriateness of using a common word like dyspareunia to encompass all of them. This objection sounds strange to a physician, who knows that any major symptom may be caused by and related to very different etiologies (multifactorial) and involve different biological systems (multisystemic). The concept of differential diagnosis exists precisely to stress the need to look at the potentially different pathophysiologies behind the common symptom that is only the emerging tip of the clinical iceberg. Dyspareunia is no exception: the difficulty is having gynecologists trained to make an early and appropriate multisystemic and multifactorial differential diagnosis.

Fifth, the great risk of including dyspareunia in the chronic pain syndromes is that this will cause a further diagnostic omission in those early cases when pain is only nociceptive, and which would be easily treated if an appropriate etiologic diagnosis were made.

Sixth, Binik suggests that including dyspareunia in urogenital chronic pain disorders would ease the funding for the research. This is the weakest argument. No other condition has been miscategorized, with the associated risk of missing many patients who could benefit from an early differential diagnosis, only to find better funding.

VV is a urogenital pain syndrome. Binik's argument is accurate for VV, but not for dyspareunia per se.

What indeed should be stressed is the frequent urogenital sexual co-morbidity, even in the earlier phases of dyspareunia. Latent class analysis of sexual dysfunctions by risk factors in women indicate that urinary tract symptoms have a relative risk (RR) = 4.02 (2.75–5.89) of being associated with arousal disorders, and a RR = 7.61 (4.06–14.26) of being associated with sexual pain disorders, according to the epidemiological survey of Laumann, Paik, and Rosen (1999). When actively asked about urogenital co-morbidity, 38.7% of my series of VV patients reported lower urinary tract symptoms (LUTS) (Graziottin et al., 2001a). In Salonia et al.'s (2004) cross-sectional study, dyspareunia was reported in 44% of LUTS patients. On average, 40% of patients report a shared pathophysiology that unfortunately has been overlooked in most of the current literature and medical teaching, with a missed or delayed diagnosis leading to chronic pain and coital pain in a significant percentage of cases. This would support broadening the category of "urogenital sexual pain disorders."

Instead of fighting for new classifications, we should urge physicians and particularly gynecologists, who naturally have the clinical and semiological background to detect the etiology of coital pain, to improve their diagnostic skills. Location of pain and its onset are the strongest predictors of its organicity (Meana et al., 1997; Graziottin, Nicolosi, & Caliari, 2001c), with the gynecological examination being able to elicit the same characteristics of pain in 90% of cases. This is a diagnostic possibility that would be missed by other physicians with no gynecological training.

Seventh and last, to maintain that dyspareunia is a sexual pain disorder would stress the fact that relieving pain is half the treatment. The other half is to (re)gain the sexual pleasure. The expression "sexual pain disorders" (or "urogenital sexual pain disorders"), inclusive of dyspareunia and vaginismus, encompasses the continuum and respects both the key features. Deleting the sexual component would mean missing a key aspect for understanding both the pathophysiology and meaning of coital pain, thus further exposing women to endless doctor-shopping in the attempt to find proper diagnosis and treatment. This is why I strongly object to this proposal.

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Classifying Pain: What's at Stake for Women with Dyspareunia

Amy Kaler, Ph.D.

Department of Sociology, 5-21 Tory, University of Alberta, Edmonton, Alberta T6G 2H4, Canada; e-mail: akaler@ualberta.ca.

As a sociologist who researches the effects of vulvar pain on women's self-concepts and social relations, I wholeheartedly support Binik's contention that dyspareunia should not be a diagnostic category in the DSM. I will not recapitulate his excellent nosological argument for considering dyspareunia a pain problem rather than a sexual disorder. Instead, I will contextualize his argument within my own research with women living with vulvar pain. Drawing from this research, I believe that the reclassification of dyspareunia is necessary and important. It is not only good science, but also has substantial implications for the lives of women who live with genital pain disorders. Based on my work, on the history of the medical categorization of dyspareunia and vulvodynia, I also argue that the retention of dyspareunia as a DSM diagnostic category is a hangover from a less enlightened era of medicine.

Since 2002, I have interviewed women with idiopathic vulvar pain producing dyspareunia about the ways in which their condition has affected their lives.[1] Participants in the study currently number over 100, recruited through the National Vulvodynia Association and other points of contact for women with vulvar pain, and have participated in either an in-person interview or a web-based open-ended questionnaire. For these women, pain during intercourse is the most significant limitation that vulvodynia places on their daily functioning, and most of the interviews have focused on the experience of persistent dyspareunia. Women draw their understandings of their own dyspareunia from the ways that others, particularly others considered knowledgeable, react to their reports of pain during intercourse. Throughout this project, I have been struck by the fact that the way that their pain is defined and categorized, whether by the women themselves, by their partners, or by the medical professionals they encounter, matters tremendously to these women.

Managing the psychological aspects of pain with intercourse emerged as the most difficult part of interaction with the medical professions.[2] When asked if they had received unhelpful medical advice or treatment

[1]This research is financially supported by the Social Sciences and Humanities Research Council of Canada through their Standard Grants programme.

[2]I should stress here that these women were quite aware that pain in such a sensitive and psychosocially significant part of the body can be connected to psychic distress, and many had sought psychological help to deal with some of the personal and relational issues surrounding vulvar pain. However, they did not believe that their pain condition was *primarily* psychological or *primarily* sexual in nature, indirectly complementing Binik and Meana's findings that the physiological manifestations of vulvar pain correspond more strongly to a pain condition taxonomy than a sexual dysfunction one.

for their pain, 34% mentioned being told that their problems were "psychological" or "all in your head" as the most unhelpful thing they had been told, compared with 6% who said that being advised to have major surgery was the least helpful medical advice they had ever received, and 6% naming the misuse of steroid creams.[3] They reported being told that they were frigid, sexually dysfunctional, repressed, or otherwise sexually abnormal because they experienced pain; in other words, in these women's encounters with medical practitioners, their accounts of pain were generalized into diagnoses that their entire sexual being was somehow sick. The retention of dyspareunia in the category of sexual dysfunction, rather than its integration into the more accurate category of pain disorder, implicitly underpins this tendency to generalize dyspareunia to a broader form of sexual failure.

Having their pain described as part of a more general sort of sexual failure was detrimental to their well-being and, in many cases, led them to believe that they were "crazy," "nuts," or a "head case," as several of them described themselves. Not surprisingly, then, 34% of participants, when asked how they felt after receiving a name and diagnosis for their condition (mainly vulvar vestibulitis or dysesthetic vulvodynia), said that their dominant feeling was "relief that I wasn't crazy." A new approach to the medical management of genital pain–an approach which defines the pain as the problem, not as a symptom of broader underlying psychiatric problems–would make a tremendous difference for women with vulvodynia.[4] The pitfalls of treating dyspareunia as if it were primarily a sexual dysfunction are evident in the testimonies of women who sought medical advice for their pain. Space permits me to include only a few of their comments:

> This is [a story] to make your jaw drop. One doctor . . . photocopied some manuals geared at 12-year-olds, about anxieties a girl might have before having sex. She implied that I must not have been ready for sex, have since been traumatized by it, and am therefore projecting pain onto myself. Here I am, an adult, being treated like a little girl who's "not ready."
>
> I am [angry] that I have this [condition] and [angry] that it isn't taken seriously and researched more. . . . I wonder how many years women have been told that this is psychological and they have sex issues.
>
> After the first month and a half of literally sobbing in the bathroom after sex [from the pain], I went to my first doctor who told me that I was frigid and I should go home and take care of my man. He said, "We [the medical profession] have a name for it. It's frigid. Go home and take care of your man." I'll never forget the quote. I was 19. . . . I thought I was crazy for years, because after that doctor I think it took six or seven more doctors until somebody had actually seen somebody else with this problem . . . I had another ten doctors tell me I was crazy, it went from "you are actually crazy" to "it's all in your head." They were sympathetic, but [they said] "Yes, you have this problem but it's all in your head and you need to go see a psychologist." That's another seven or eight years of doctors saying, "This [vulvar pain] is bizarre but it's all in your head, go and see a psychiatrist." Then I went to pain management [clinic and] they had people with migraines and back pains and so that is when I began to see that this is a problem that other people have and I am not crazy.

The classification of dyspareunia as a sexual dysfunction is a holdover from a less enlightened era of medicine, in which women's reports of pain were much more likely than men's to be met with some form of the "it must be in your head" explanation from their doctors, including gynecologists. At the same time, poorly-informed Freudian notions about the relationship between gender and sexuality influenced some (though not all) doctors' responses to patients who complained of genital pain. Genital pain was thus vulnerable to being read as a manifestation of disturbances of women's minds and social relationships, rather than as an organic ailment (Kaler, 2003).

Painful intercourse is far from the only health problem hampered by excessive psychological attribution. Many conditions which afflict primarily women and which are characterized by pain have been ascribed to psychological problems, including endometriosis, premenstrual syndrome, chronic fatigue syndrome, and migraine headaches. Vulvar pain, however, has attracted a great many psychosocial explanations, even when compared with other pain conditions with equally mysterious etiologies. Unlike headaches or joint pain, vulvar pain is located in the very part of the body said to define womanhood, femininity, and sexuality. Within the medical history of the last century, women's sexual organs and their disorders have been amply endowed with symbolic significance for the state of women's psyches and social lives.

[3] These answers were generated spontaneously in response to an open-ended question; in other words, the women were not presented with a list of possible answers to choose from.

[4] Removing dyspareunia from DSM-IV is not just a matter of doing something nice for women so they feel better about themselves. Women's conception of their pain as physical or psychological has definite consequences for pain severity. With respect to dyspareunia, Meana, Binik, Khalifé, and Cohen (1999) investigated the relationship of women's attribution of pain during intercourse to measures of pain experienced, independent of organic pathology. Women who believed their pain was caused by psychosocial factors such as relationship problems or anxiety reported higher levels of pain and distress than did women who believed their pain was due to physical factors.

Fortunately, clinical understandings of vulvar pain have moved past the point of ascribing it to psychological dysfunction. In the latter quarter of the 20th century, medical understanding of genital pain has gone from a paradigm in which it was understood as a manifestation of marital problems, to a paradigm in which it was understood as a characterological dysfunction, to, finally, a paradigm in which it is understood *primarily* as a pain phenomenon, which may or may not be an expression of underlying psychological or social conflicts (Kaler, 2003).

Compare, for instance, Dodson and Friedrich's (1978) description of women with dyspareunia as "...manifest[ing] signs of neurosis, dependent personality, guilt feelings, emotional lability while denying psychological difficulties... [who] receive a secondary gain from their symptom complex, i.e., a reason not to engage in sexual activity....Patients with persistent symptoms should be promptly referred for psychiatric care" (pp. 24–25) with the more recent approach advocated by Graziottin et al. (2001), in which clinicians are urged to begin their treatment by creating a detailed "pain map" which focuses on the specific qualities of the pain (intensity, localization, duration, quality, etc.), thereby making the pain itself the focus of attention, rather than assuming that the pain as a symptom of underlying problems, be they psychological or physiological. By extracting dyspareunia from the category of sexual dysfunction and subsuming it under the category of pain disorder, Binik's proposal to amend the DSM-V will reflect this evolution in the understanding of genital pain.

Perhaps pain during intercourse might be conceptualized by analogy with weight loss. Like dyspareunia, weight loss is a subjective bodily experience the etiology of which is often difficult to identify. Some cases of weight loss are associated with psychological disorders, such as bulimia or anorexia, and other cases are associated with medical conditions not thought to have a psychological component, such as hyperthyroidism or parasitical infection. Weight loss thus properly appears in the DSM-IV as a symptom which, in conjunction with other criteria, *may* warrant the use of a diagnostic category. However, weight loss is not a diagnostic category in and of itself, and any move to give it independent categorical status would clearly be inappropriate. So too, then, with dyspareunia. Pain during intercourse is a functional problem which *may* signify the presence of a psychological disorder, but it is not a disorder unto itself.

I congratulate Binik on his radical but eminently sensible proposal to move dyspareunia into the category of pain disorder, and hope that other clinicians and researchers will also see the wisdom of this proposal.

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Adding Insult to Injury: The Classification of Dyspareunia as a Sexual Dysfunction in the DSM

Peggy J. Kleinplatz, Ph.D.
School of Psychology, University of Ottawa, Ottawa, Ontario K1N 6N5, Canada; e-mail: kleinpla@uottawa.ca.

Binik is to be commended for his recommendation that Dyspareunia be removed from the Sexual Dysfunction section of the DSM. There are a variety of conceptual, empirical, and practical problems with the classification of Dyspareunia as a sexual dysfunction. The purpose of diagnostic classifications is to offer a clinical shorthand so as to facilitate treatment decisions and research. If the diagnosis is erroneous or misleading or if the foundations for its classifications are faulty, treatment can be compromised and research misdirected.

In the first two editions of the DSM, which were psychoanalytically based, "sexual" pain was classified under psychosomatic pain. With the advent of the DSM-III (American Psychiatric Association, 1980), the goal of the DSM was to be empirically based and atheoretical but attaining this goal has been elusive. "Sexual" problems came to be treated differently and classified separately from the "non-sexual" disorders. In the DSM-III, Dyspareunia was classified as a "Sexual Dysfunction." It was specifically excluded from the pain disorders, that is, from the section of the DSM where Binik argues so persuasively that it rightfully belongs. The flaws Binik has demonstrated in the Dyspareunia diagnosis as defined in the DSM parallel those discussed previously in reference to the Paraphilias (Moser, 2001; Moser & Kleinplatz, in press). The argument that the APA has not fulfilled its own criteria for classification and inclusion in the DSM is discussed by Moser (2005) in his commentary.

"Sexual" behaviors and "sexual" pain have been singled out as different and distinct from other kinds of problems and pain. The rationale for this shift has neither been justified on theoretical grounds nor is there evidence to support the distinguishing of "sexual" problems on empirical grounds. Problems related to sex have been pathologized as if they were, in essence, "sexual" and diagnostically distinct without the scientific data to back up this nosology (Moser, 2001; Moser & Kleinplatz, in press).

The trend towards pathologizing "sexual" problems has not abated; on the contrary, some (Carnes, 1991, Kafka, 2001) have proposed the addition of other sexual diagnoses (e.g., "sexual addiction" and "nonparaphilic hypersexuality"), without the requisite empirical evidence, to the DSM.

It may be illusory to think that we can analyze sexual problems atheoretically and devoid of the sex-negative context in which they occur and are regarded as pathological. Diagnosing problems as "sexual" may add to the stigma surrounding common difficulties and may ultimately impede appropriate intervention.

The difficulty in sorting out what constitutes a sexual dysfunction (illustrated by numerous critiques of the 2000 Consensus Conference on female sexual dysfunctions published as a special issue of the *Journal of Sex & Marital Therapy* [Segraves, 2001]) is complicated by the *lack* of consensus surrounding what constitutes sexual "normalcy," health, or well-being. Substantive theoretical and empirical formulations are conspicuously absent with regard to the nature of sexual problems, let alone the specifics of how to delineate, identify, and classify them.

In the DSM-IV-TR, a sexual dysfunction is defined as "...a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse" (American Psychiatric Association, 2000, p. 535). This definition and, more specifically, the wording of the Dyspareunia section illuminate the heterosexist bias in this diagnosis, as there must be "...genital pain with sexual intercourse" (American Psychiatric Association, 2000, p. 556). Not everyone is heterosexual or wants to engage in intercourse. In addition, the section is oriented towards function versus dysfunction (i.e., performance) rather than pain and pleasure (i.e., subjective experience).

In some instances, the DSM nosology has hindered treatment of complex biopsychosocial problems. In practical terms, the separating out of sexual problems from other problems works to the disadvantage of many patients. In the case of women who present with pain on intercourse, the diagnosis of Dyspareunia as a sexual disorder emphasizes the manifestation of the problem rather than the underlying problem, leading to the treatment of the wrong problem. Many different problems can be confounded that are actually quite disparate in nature, from episiotomy scars to infections and from tumors to endometriosis. Thus, another reason for supporting Binik in removing the designation of genital pain as a sexual disorder is to refocus attention and thereby to get at useful directions for treatment.

In the existing nosology, clinicians end up treating either the mind or the body rather than the woman or the couple who suffer from her genital pain. The etiologic subtype must be either psychologic or combined (i.e., physical and psychologic etiology). Pain caused by a physical problem, without a psychological component that has a role in the cause or maintenance of the pain, is excluded. The current designation supports mind-body dualism. The causes of genital pain are often difficult to ascertain on medical examination. When no organic cause is readily identifiable, the woman is often (mis)treated as if the pain were all in her head. The pain aspect of this painful disorder has been overlooked and misdiagnosed, whether we regard it as "psychogenic" or "organic." Regardless of the origins of her pain, which certainly merit appropriate investigation, the outcome, that is, her pain per se and its effect on the woman and her relationship(s) are often ignored or treated inadequately.

Binik reports being surprised upon discovering that no instruments were available for measuring female genital pain given the ready availability of measures for corneal, oral, penile, and other bodily pain. His surprise seems surprising. Women's pain at physical complaints is often minimized, such that the underlying disorders are often overlooked. If the complaint is regarded as "sexual," women are often doubly dismissed. Clinicians tend to trivialize and dismiss suffering which affects sexuality, whether in the routine treatment of arthritis and diabetes–most egregiously in women; we create and exacerbate iatrogenic sexual problems via chemotherapy, breast augmentation, the "management" of childbirth, treatment of depression and anxiety; we often ignore the sexual component of rehabilitation from heart attacks, strokes, traumatic injury, and other chronic illnesses and disabilities.

Binik's analysis leads to implications for the training of physicians and other clinicians. Physicians who are uncomfortable with sexuality must learn to deal with it (Maurice, 1999) rather than dumping/transferring the patients (and problems) who disquiet them into the hands of mental health professionals as a default option. Physicians who are trained to ask a series of questions routinely about pain (e.g., "Where does it hurt?" and "What seems to trigger or exacerbate the pain?") tend to get rather squeamish when enquiring about genital pain. At present, too many women are at risk of falling through the cracks in the medical system because no one has either established the location of their pain nor determined when in the course of which sexual or other acts it seems to hurt most.

Unfortunately, no matter where the diagnosis is placed, we have paid too little attention to the treatment of pain. Placing Dyspareunia into the pain section will not mystically solve this problem nor will patients automatically receive better care. Binik's argument suggests that we will be needing either clinicians who are specialized in dealing with both sexuality and pain or integrated, multidisciplinary teams to deal with women (and perhaps men) who experience genital pain.

Binik is convincing in his argument that Dyspareunia should be removed as a Sexual Dysfunction from the DSM-V. It may also be time to re-evaluate the entire

classification of "sexual" disorders in the DSM. If there is neither theoretical rationale nor empirical evidence nor clinical advantage in such designations, as is clearly the case with Dyspareunia, the foundations for this section warrant careful scrutiny with an eye to pruning other diagnoses that do more harm than good.

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A Slightly Different Idea

Stephen B. Levine, M.D.
Center for Marital and Sexual Health, 23230 Chagrin Blvd., #350, Beachwood, Ohio 44122; e-mail: sbl2@case.edu.

The classification of disease states is an ever-evolving phenomenon. Every specialty transforms its nosology in response to new scientific findings and the theoretical paradigms they stimulate. Psychiatric nosology is no exception, but it is also responsive to cultural and political movements. The etiology, pathogenesis, and natural history of relatively few medical diseases are thoroughly understood despite our ability to effectively treat, delay, and sometimes prevent morbidity. I cannot think of a single serious mental illness that is profoundly understood in these terms, even though there is buoyant hope that one day soon scientists will find the molecular and neurophysiological bases for emotional suffering. Many common, chronic, disabling, and baffling problems involve pain–fibromyalgia, irritable bowel syndrome, migraine headaches, and dyspareunia to name but four. They find their way to both physicians' and mental health professionals' offices. Binik, who has led more than a decade of scientific inquiry into the symptom of pain during intercourse, wants the DSM-V to change the way one of these is classified. When he speaks, we should listen carefully.

The DSM-IV-TR, like its earlier iterations, is a tool for educating students, organizing and funding research, and triggering payment for clinical services. It contains many controversies. Despite its utility during clinical evaluation processes, it is not particularly useful to experienced clinicians, who are more focused on how to intervene with the forces that maintain a problem than how to classify the problem. There are many ways to diagnose and understand problems (Kendell & Jablensky, 2003). Uncertainty about the validity and meaning of sexual diagnoses peak at higher levels for women's than men's sexual concerns (Bancroft, Loftus, & Long, 2003; Nathan, 2003). Binik's suggestion to reclassify dyspareunia as a pain disorder is the second recent attempt to redo aspects of the nosology of female sexual dysfunction. The first attempt was stimulated by the anticipation that a PDE-5 inhibitor would be a great help to women with arousal dysfunctions (Basson et al., 2000). It is now languishing because the efficacy of sildenafil for these women could not be convincingly demonstrated to exceed placebo response rates (Berman, Berman, Toler, Gill, & Haughie, 2003). In addition, many felt that the distinctions made between arousal and desire disorders in numerous studies were arbitrary (Levine, 2003). I bring this up because the most compelling reason to change any nosology is a clarification of a condition's etiology, pathogenesis, natural history, or treatment. It is not the hope of future findings.

Many medical conditions share the nosological dilemmas of Dyspareunia. Chronic Obstructive Lung Disease (COPD), for example, is a codable diagnosis that is not a single entity. Like the painful response to intercourse in Dyspareunia, COPD is a collection of conditions that share a physiological impairment–a marked limitation of expiratory airflow. COPD patients vary in color and weight ("pink puffers" vs. "blue bloaters"), exercise capacity, impairments in other organs (Rennard, 2004) and psychological response to their condition. Despite assumptions that COPD is caused by smoking, 20 percent of patients have never smoked. While COPD can be fatal, Dyspareunia might only be fatal for patients' aspiration of sexual fulfillment.

The symptom of painful genital activity, which we refer to as *dys*pareunia, becomes a diagnosis, *Dys*pareunia, when gynecological attention fails to explain or eradicate the symptom. Painful intercourse due to metastatic cancer to the vagina is only *dys*pareunia–it is not Dyspareunia. Patients with Dyspareunia vary in terms of sensitivity to vulvar touch, associated spasms of the pelvic floor musculature, interest in other sexual activities, and the characteristics of the pain. Like all chronic conditions, Dyspareunia has numerous psychosocial impacts on the woman and her sexual partner (Bergeron, Meana, Binik, & Khalifé, 2003). It is now clear that the original sex therapy techniques for Vaginismus and Dyspareunia do not adequately address the dread of pain, the pain itself, and the intersection of forces than maintain the pain. Modern treatment involves multiple modalities and multiple professionals. The results, as Binik has enumerated, are respectable, although no one is shouting "cure" or promising a voluptuous sexual life. We should not overlook the fact that we do not know very much about the untreated natural history of Dyspareunia.

If we classify Dyspareunia as a sexual dysfunction, we imply that it significantly interferes with the symptom bearer's sexual desire, arousal, and orgasm sequence. In fact, it does often, but not invariably. Some women learn to avoid genital activities that cause pain and still manage to have orgasms regularly. Others have intercourse despite the pain. Binik's group has ascertained that most of the

women with Dyspareunia have reduced indices of sexual activity. Keeping Dyspareunia under the rubric Sexual Dysfunction will continue to alert clinicians that the pain significantly impairs sexual life. It does not dictate that the treatment approach should be "sex therapy," whatever that now means. Afterall, we give a PDE-5 inhibitor for erectile dysfunction to most patients without sex therapy.

If we classify Dyspareunia as a pelvic floor disorder, as the physical therapists do, we would be emphasizing the hypertonicity of the circumvaginal and pelvic girdle muscles. The patients who have no muscular obstruction to penetration in the face of pain don't get to the physical therapists for treatment. Those who do are often helped significantly. The physical therapists' vaginal examination can more sensitively detect and treat the hypertonicity than the gynecologist whose focus is not primarily on musculature.

If we classify Dyspareunia as a pain disorder, as Binik suggests, it might lead to more referrals to the pain management teams. Research into genital pain conditions might be more easily funded. The problem is more likely to get multidisciplinary attention in large medical centers. But, paradoxically, few pain management teams have a tradition of comfort and skill in dealing with sexual life. Perhaps this would be a loss as the patient certainly is aware of her sexual limitations.

I am not convinced that science has already leapt forward in clarifying the etiology, pathogenesis, or natural history of Dyspareunia. It is not as though health professionals did not know the problem was pain; it was that we didn't know how to eradicate it. We still do not understand how it is set up. Binik has played a great part in demonstrating that, despite the unanswered questions, today a woman with Dyspareunia can be far better treated than in the past. The treatments, which in no sense should be disparaged, do not make the problem disappear. There is much work to be done on this and other common impediments to sexual comfort and pleasure.

While I am not opposed to Binik's suggestion, neither am I greatly enthusiastic about it. I agree the name should be changed from Dyspareunia because of the obvious confusion between the symptom and the diagnosis and the history of the neglect of the problem.

I have a suggestion. Let's call the problem Chronic Obstructive Vaginal Disease (COVD). The pathogenesis is known to involve various combinations of pain, fear, dread, and spasm. The etiology must be further studied not only with groups of cases, but through careful case-by-case life history studies within the emerging subgroups, such as VVS. COVD implies no hegemony of any one group of specialists as urogenital pain disorder might. Instead, we should build upon Binik's work and assemble teams of mental health professionals, pain specialists, physical therapists, gynecologists, and perhaps even the clergy to carry the important work forward.

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Dyspareunia: A Pain Disorder or Sexual Dysfunction?

Atef R. Markos, FRCOG, FRCP
Genito Urinary Medicine and Sexual Health, Staffordshire General Hospital, Weston Road, Staffordshire ST16 3SA, England; e-mail: stephanie.thorpe@msgh-tr.wmids.nhs.uk.

Sexual function is the latest discipline of human physiology to be investigated scientifically. Our current knowledge regarding sexual function and dysfunction is in a state of metamorphosis, with scarce scientific analysis and few controlled studies (than most of the other disciplines). The ongoing discussion regarding the classification of dyspareunia (as pain disorder or sexual dysfunction) paves the way for debating and pooling ideas, for scientific research, and investigations. The final goal should be addressing patient's concerns in a uniform, professional, and research guided manner for furthering the science, art, and discipline of sexual medicine.

Sexual function should be viewed as an interaction between two human individuals with a balanced cycle of desire, performance (arousal and orgasm), and intimacy. *Sexual dysfunction* could then be identified as the symptomatic recognition (of either individuals) of disruptive imbalance in the sexual function cycles. The sexual relationship is particular, specific, and individual to each and every couple. Consequently, any perceived disharmony or dysfunction is specifically addressed and individually managed, in relation to that particular couple's relationship.

Pain, distressing as it is to patients, serves the important function of attracting the patient's (and physician's) attention to an underlying problem, while providing rest (dysfunction) to the organ in question. Pain is defined by the International Association for the study of pain (IASP) as *"an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage*" (Mersky & Bagduk, 1994). Many clinicians would identify with this definition. They would acknowledge the complexity of pain, as a phenomenon, and the discrepancy between tissue damage, perception of magnitude of pain, and the possible impact on the individual's physical and psychological function. This is apparent in both women and men who experience pain during sex, with impact on the physical, psychological, and/or sexual functions (of either or both partners). Dyspareunia is also complicated

by the involvement of two individuals (when one, or both, could experience pain and one, the other, or both, may suffer the consequences of dysfunction (being sexual or otherwise). The recognition of the American Pain Society of pain as the "*fifth vital sign*" implies that health care workers should actively seek to assess, record, interpret and manage pain (McCaffory & Paseroc, 1997). This represents a striking development in the attitude of the medical establishment towards pain. The responsibility of the healthcare team was perceived previously as to control the patient's expression of pain (Fogerhaugh, 1974). Good clinical practice guidelines (General Medical Council [GMC] of the United Kingdom, 2004) advocate that the doctor "*must provide the necessary care, to alleviate pain and distress, whether or not curative treatment is possible*." The previous set of guidelines did not address pain or give it such recognition (GMC, 2004). The listing of "sexual pain" and its classification by the American Psychiatric Association furthers the interests and responsibilities of the health care profession in its management.

Dyspareunia is usually perceived as a female disorder, ignoring the clinical observation that males may experience and complain of pain during sexual intercourse. There is also the misconception that sexual dysfunction, as a result of dyspareunia, is a feminine symptom. Clinical experience and public convention indicate that men suffer sexual dysfunction, and impotence, when sexual intercourse becomes associated with suffering and agony of the female partner. This is why "sexual dysfunction" should be considered as a reflection of the *sexual relationship of the couple* and not a unique problem of one partner only in the relationship. On a therapeutic level, the management of dyspareunia will need to be designed in relation to the couple's specific situation and circumstances (whether one or both complain of dysfunction). Clinically, if either partner is suffering from sexual pain, either or both parties may end up with sexual dysfunction. Understandably, the pain and dysfunction come to the attention of the medical establishment when either or both partners complain (if the suffering is long, severe, embarrassing, and/or leading to disruption in the relationship). Practically, we do not know the incidence, frequency, duration, pattern, recurrence, severity, type, causes, treatment, and/or response of dyspareunia. We do not know either about its prevalence in different age groups, personality types or cultural, socioeconomic, and/or ethnic subgroups. The role of the intermix of partners and couples (within all the above variables) is not identified either. We don't know of the incidence of dyspareunia as an etiology of sexual dysfunction. What we cannot ignore clinically is that many partners who suffer pain during sexual intercourse experience, complain of, and seek treatment for sexual dysfunction. The incidence of patients who have dyspareunia but suffer no sexual dysfunction is not known either. Notably, there are conditions when dyspareunia may be the prevailing problem and where sexual dysfunction is of secondary concern to the couple. In other conditions, dyspareunia may be mild/moderate, but recurrent, and could lead to sexual dysfunction. The relative female to male contribution of the cause (dyspareunia) and result (sexual dysfunction) requires further investigations.

Clinical experience indicates that the majority of patients who complain of dyspareunia would seek the management of pain, expecting that any associated sexual dysfunction will consequently resolve. On investigation, many cases would have an underlying organic cause, the treatment of which will cure both pain and dysfunction. In fewer cases, the organic cause may not be curable and, therefore, the clinical course would seek to address alleviating pain and dysfunction. Sexual pain could be of short duration and low intensity and, therefore, is not perceived by either partner as of dysfunctional importance. In other occasions, the main problem is sexual disharmony and dysfunction when the female partner may revert to dyspareunia as an excuse for disengagement.

In our current stage of clinical knowledge, the view that dyspareunia should be considered as a pain disorder rather than a sexual disorder is going to be based on collective opinions rather than scientific research. It is also impractical to attempt to reverse the classification without supportive evidence. The learned opinion, of clinicians working in the field of sexual medicine, should be supplemented by extensive research and investigations. The view that dyspareunia should be considered as a pain disorder rather than a sexual dysfunction should not be viewed as too pedantic and ignores theoretical rational and supporting clinical experience and evidence. The debate regarding the classification of dyspareunia should lead us to research these questions. The answers should help us to respond to the specific concerns of the couple (i.e., pain or sexual dysfunction), which must be prioritized and managed accordingly. The findings should help to identify the relative contribution of either condition to the other and their prevalence in the population and consequently their categorisation as disease disorder.

In conclusion, more patients complain of sexual pain than dysfunction on presenting with dyspareunia. The patient and the clinician would seek to address the pain problem as the first step and, therefore, it would be appropriate to classify dyspareunia under pain disorders. Our suggestions emerge from the current state of knowledge and more research into the relationship between dyspareunia and sexual dysfunction would help to clarify

the situation to clinicians, to the benefit of our patients. The research should improve our understanding of the prevalence, etiology, and management of dyspareunia so that we may conduct our responsibility and duty of care to alleviate the patient's pain and dysfunction (be it sexual or otherwise).

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Revisiting the Diagnosis of Dyspareunia: A Painful but Important Discussion

Robin Masheb, Ph.D., and Susan Richman, M.D.
Department of Psychiatry, Yale University School of Medicine, POB 208098, New Haven, Connecticut 06520-8098; e-mail: Robin.Masheb@yale.edu.

The essay by Binik addresses an important and timely question: Should dyspareunia be retained as a sexual dysfunction in DSM-V? The diagnosis of dyspareunia has been passed down from previous editions of the DSM with little scrutiny or empirical support for its validity as a diagnostic entity. We would like to praise Binik for inciting a dialogue and creating an opportunity that will hopefully lead to a paradigm shift in our thinking. Research of women's sexual dysfunction and women's urogenital pain disorders will undoubtedly benefit from such a frank and much needed discussion.

In reading this commentary, please note that we treat patients with vulvodynia within a collaborative and multidisciplinary medical setting. Our approach to treatment is grounded in a chronic pain framework, which is one of the three perspectives to understanding dyspareunia described by Binik. Similar to many other issues, we feel strongly that questions surrounding the classification of dyspareunia hinge upon one's adopted perspective. We would like to comment on Binik's analysis of the three proposed perspectives: a sexual dysfunction approach, a chronic pain approach, and a gynecologic approach. For each, we raise a relevant diagnostic question and provide our suggestions for a classificatory course of action.

A Sexual Dysfunction Approach

Binik takes a chronic pain perspective and he lays forth quite compelling theoretical arguments against classifying dyspareunia as a sexual dysfunction. First, current diagnostic criteria for pain disorder imply there are two types of pain in the world (i.e., sexual and non-sexual pain). Second, the current diagnostic criteria for dyspareunia do not account for genital pain associated with other activities (e.g., tampon insertion) that may reproduce the same pain experienced with sexual activity. Third, unlike other pain syndromes, the diagnosis of dyspareunia is defined by disruption of function.

It is disappointing that the definitions and classifications of female sexual dysfunction have not moved forward despite efforts to revise existing criteria (Basson et al., 2000). Unfortunately, a major limiting factor has been the lack of research and funding for women's sexual dysfunction. Little data exist regarding the prevalence of dyspareunia in different populations (e.g., community samples, women with sexual dysfunction, post-menopausal women, etc.). Furthermore, reliable and valid criteria for dyspareunia as a diagnosis do not exist. In addition, it is similarly unknown whether sex therapy for dyspareunia is effective, as there have been few controlled clinical trials using sex therapy for women with dyspareunia.

Probably the greatest obstacle for dyspareunia as a DSM diagnosis is the considerable co-morbidity with other sexual dysfunctions and medical conditions. For example, there is a fair amount of empirical data that contradicts the distinction between dyspareunia and vaginismus.

This raises the question of whether dyspareunia is useful as a DSM sexual pain disorder or rather as a symptom of other sexual disorders. Given the absence of empirical support for the diagnosis, we feel Appendix B in the DSM-IV, which contains criteria sets for further study, represents a more appropriate placement for dyspareunia.

A Chronic Pain Approach

Binik's empirical arguments for a chronic pain approach are also compelling, despite the small literature which provides their basis. In our own laboratory, we have implemented and encouraged a multidimensional assessment of pain for patients with vulvodynia (Masheb, Nash, Brondolo, & Kerns, 2000). Using psychosocial measures relevant for chronic pain patients, we have found that women with chronic vulvar pain report worse functioning on these measures than women without any chronic pain (Masheb, Brondolo, & Kerns, 2002). This lends support to Binik's argument that physical and psychosocial correlates of dyspareunia are more relevant to pain. Furthermore, in a nearly completed trial of 50 women with vulvodynia randomly assigned to individual cognitive-behavioral therapy (i.e., a chronic pain treatment adapted for vulvodynia) or supportive psychotherapy, we are finding (1) greater than 40% reductions in pain severity; (2) statistically significant decreases in dyspareunia, and (3) statistically significant improvements in overall sexual function. These results are similar to those reported by Bergeron et al. (2001) for group cognitive-behavioral therapy for women with vulvar vestibulitis syndrome, but with a more

heterogeneous sample of vulvodynia patients. These findings also provide further support for Binik's argument that pain therapies are effective in treating dyspareunia.

While we are in favor of Binik's proposal to develop a classification system for the different urogenital pain syndromes, clearly more research is needed to determine which conditions are distinct entities. For example, to date, little empirical evidence exists to support the proposed subtyping of vulvodynia.

Thus, another important question is whether dyspareunia should be dropped as a DSM sexual pain disorder, but kept as a possible symptom of other pain disorders. At a minimum, we feel the qualifier "does not meet criteria for Dyspareunia" should be eliminated from the diagnostic criteria for Pain Disorder, so that patients suffering from urogenital pain conditions, such as vulvodynia, would be included under this diagnosis.

A Gynecologic Approach

From the organic/gynecological perspective, understanding dyspareunia as a symptom, rather than as a diagnosis, has been extremely helpful. The symptom leads the gynecologist to consider numerous differential diagnoses of medical etiologies for vulvar and/or vaginal pain, either with or without penetration. These may include, but are not limited to vaginitis, vulvar dermatoses, pudendal neuralgia, myofascial injury, coccygodynia, chronic interstitial cystitis, endometriosis, adenomyosis, urethral diverticulum, pelvic inflammatory disease, peripheral neuropathies, and hypoestrogenic states; however, when all of the above are ruled out or available treatments are deemed ineffective, gynecologists and healthcare professionals are at a loss for recommending a course of action. One advantage of conceptualizing dyspareunia as a pain problem, rather than a sexual problem, is that pain management options would be considered in these scenarios.

Recent attention to the assessment and treatment of pain in primary care settings originated from the American Pain Society which created the phrase "Pain: The 5th Vital Sign," and has since been promoted and accepted by other national health organizations. Estimates for dyspareunia range from 6.5% to 13% (Danielsson, Sjöberg, Stenlund, & Wikman, 2003). Lifetime and point prevalence rates of vulvar pain are 16% and 7%, respectively (Harlow & Stewart, 2003). While there may be considerable overlap, clearly these numbers suggest that pain of the urogenital tract is a significant public health problem.

This raises the final question of whether dyspareunia should be dropped as a DSM diagnosis, but kept as a symptom of conditions of the vulva, vagina, and pelvis. We feel it is imperative that healthcare professionals assess for pain of the urogenital tract similar to pain in other areas of the body.

Conclusion

Given the lack of empirical support for dyspareunia as a DSM diagnosis, at a minimum, dyspareunia should be relegated as a category for further study. Furthermore, eliminating the qualifier "does not meet criteria for Dyspareunia" from the criteria set for Pain Disorder would allow for the inclusion of pain conditions of the urogenital tract. More research is needed to differentiate disorders of the urogenital tract, and more training and advocacy is needed to make healthcare practitioners aware of urogenital pain conditions.

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Teasing Apart the Pain from the Sex: Is the Pendulum Swinging Too Far?

Marta Meana, Ph.D.
Department of Psychology, University of Nevada, Las Vegas, 4505 Maryland Parkway, Las Vegas, Nevada 89154-5030; e-mail: meana@unlv.nevada.edu.

When Binik and I first reviewed the dyspareunia literature over 10 years ago, we found a dearth of empirical research, inconsistent use of an inadequate taxonomy, dualistic theorizing about etiology, and a lack of controlled treatment outcome studies (Meana & Binik, 1994). No surprise there. This was and continues to be true of a good part of the literature on any number of disorders, the female sexual dysfunctions being no exception (Heiman, 2002; Heiman & Meston, 1997; Schover & Leiblum, 1994). The truly striking feature was the lack of research or clinical emphasis on the one and only presenting symptom of dyspareunia: pain. No one seemed interested in the properties of the pain or in their relation to etiology and/or treatment.

Ten years later, the literature looks dramatically different. The surge of excellent pain-centered dyspareunia research, mostly emanating from Binik's lab, has largely remedied the once glaring omission. As Binik's first collaborator in this research effort and clearly a proponent of the pain approach, I am nonetheless concerned that it may be premature and even unadvisable to embrace his conclusions just yet. Do all the data really indicate a reconceptualization of dyspareunia as a pain disorder rather than as a sexual dysfunction? And, even if they do, will the transfer of dyspareunia from the "Sexual

Dysfunctions" into the "Pain Disorders" section of the future version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) have its intended effect or could it risk banishing dyspareunia from research and clinical consciousness? I will attempt to address these two concerns and suggest a friendly amendment to Binik's main motion.

Where Have All the Subtypes Gone?

Binik builds his empirical argument for a pain disorder conceptualization of dyspareunia on a number of recent studies (Bergeron et al., 2001, 2002; Granot, Friedman, Yarnitsky, & Zimmer, 2002; Meana, Binik, Khalifé, & Cohen, 1997a, 1997b; Pukall, Binik, Khalifé, Amsel, & Abbott, 2002; Pukall, Strigo, Binik, Khalifé, & Bushnell, 2003). The problem here is that the samples in all but the Meana et al. (1997a, 1997b) study consist exclusively of women with vulvar vestibulitis syndrome (VVS). VVS is but one type of dyspareunia, yet Binik uses the terms interchangeably at various points in his argument. Now, further data collection may indicate that close to all of pre-menopausal dyspareunia is indeed VVS, but we are not there yet. Furthermore, the little comparative data we have from the original Meana et al. (1997a, 1997b) study indicate otherwise.

The diagnostic dyspareunia subtypes in the Meana et al. (1997a, 1997b) study consisted of three substantial groups: no obvious physical pathology, VVS, and mixed physical findings. For the purpose of illustration, I will focus on the no-obvious-pathology group, which represented a quarter of the sample. Unlike the VVS group, whose pain was without exception introital and linked to all types of introital stimulation, a pain profile could not be produced for the no-obvious-pathology group. Pain location was equally distributed in a diffuse presentation across six possible sites. Although there were significant reports of pain with activities other than sexual intercourse, only 54% reported pain with gynecological examinations and a whole 30% reported pain with non-penetrative sexual stimulation, compared to only 17% of those with VVS. In terms of a psychosocial profile, the no-obvious-pathology group was the only one to report significantly elevated psychological symptomatology (obsessive compulsive tendencies, interpersonal sensitivity, depression, phobic anxiety) and relationship maladjustment in comparison to controls (Meana et al., 1997a, 1997b).

Thus, in relation to Binik's argument for the primacy of pain over sexual dysfunction, this dyspareunia subtype does not fit the bill quite as neatly as the VVS one does. The pain does not seem to have a specific location, it seems more closely linked to sexual context, and psychological symptomatology is fairly prominent. A couple of caveats are in order here. The sophistication of our pain measurement in that study had not reached the levels later attained by both Bergeron et al. (2001) and Pukall et al. (2002). It is possible that the use of the vulvogesiometer would have resulted in a re-classification of these cases, yielding different results. In addition, our sample was comparatively small; however, the distinctiveness of this sub-sample suggests the possibility of a subtype of dyspareunia notably different from VVS in terms of pain and psychological characteristics. I offer it as an example to moderate and delay conclusions about dyspareunia based primarily on data from VVS cases. Would we find sensory dysregulation and a typical pain signature in the brains of women with other types of dyspareunia? We do not know because they have not been studied. Would findings one way or another characterize the pain these women report as less of a Pain Disorder and more of a sexual dysfunction? Maybe the time has come for us to think about this a little differently.

Dyspareunia in the Pain Disorders: Moving Up or Moving Out?

Binik's argument for moving dyspareunia out of the Sexual Dysfunctions into the Pain Disorders seems empirically premature, given the dearth of data on anything but VVS. It may also be theoretically and practically questionable. Without venturing into the quagmire of discussing the myriad factors that should determine psychiatric classification in the DSM-V, let us examine some of the potential gains and losses of this move.

There is little question that the pain emphasis we initiated a decade ago has been a productive and clinically significant development, at the very least in our understanding and treatment of VVS. Treatments have incorporated elements of the pain management repertoire (e.g., physical therapy, hypnosis, surgery) and possibly augmented the efficacy of more traditional sex therapy techniques, such as vaginal dilatation, script modification, and arousal enhancement. This has all happened without a re-classification and the momentum promises to continue. The "dyspareunia is better than no pareunia at all" forces seem to be in retreat and it is hard to believe that they will rise again. The existing empirical support for the intensity of the pain felt by these women and the negative impact of the disorder on their individual and relational well-being is likely to inform all future empirically validated treatment efforts.

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.

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Dyspareunia: Another Argument for Removal

Charles Moser, Ph.D., M.D.
Institute for Advanced Study of Human Sexuality, 45 Castro St., #125, San Francisco, California 94114; e-mail: docx2@ix.netcom.com.

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 "Psychophysiologic Autonomic and Visceral Disorders" (American Psychiatric Association, 1952, p. 29), different psychophysiologic 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 "Psychophysiologic 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 Psychophysiologic 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 Psychophysiologic 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.

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Making the Case for Sexual Pain: Let's Not Throw Out the Baby with the Bath Water

Kimberley Payne, B.A.
Department of Psychology, McGill University, 1205 Docteur Penfield Avenue, Montreal, Quebec H3A 1B1, Canada; e-mail: kimpayne@ego.psych.mcgill.ca.

In Binik's critique of the current DSM-IV-TR classification of dyspareunia (American Psychiatric Association, 2000), he provides evidence for the following three assertions: (1) dyspareunia fits the diagnostic criteria for a Pain Disorder; (2) dyspareunia does not fit the category of Sexual Dysfunctions; and (3) a re-conceptualization of dyspareunia under the category of Pain Disorder will have a positive influence on research and treatment. While Binik provides substantial conceptual and empirical evidence for the first assertion, which therefore need not be addressed, the other two assertions remain problematic. What follows is a critique of Binik's position and an alternative solution to the categorization dilemma posed by the concept of sexual pain.

According to Binik, dyspareunia does not fit the category of sexual dysfunctions primarily because these are organized according to the phases of the sexual response cycle with which they interfere. Thus, the section is as follows: Sexual Desire disorders, Sexual Arousal Disorders, Orgasmic Disorders, and finally, Sexual Pain Disorders. However, it remains uncertain why this organizational detail should constitute a critique of the categorization of dyspareunia as a sexual dysfunction, unless of course the implication is that dyspareunia does not interfere with any phase of the sexual response cycle. It has been repeatedly shown that women with dyspareunia experience impairment across all stages of the sexual response cycle, including but not limited to, lower frequencies of intercourse and self-stimulation, lower levels of desire, arousal, pleasure, and lubrication, less success at achieving orgasm, a more negative sexual self-schema, and more negative feelings and attitudes regarding sexuality (Gates & Galask, 2001; Jantos & White, 1997; Meana, Binik, Khalifé, & Cohen, 1997; Nunns & Mandal, 1997; Reissing, Binik, Khalifé, Cohen, & Amsel, 2003; van Lankveld, Weijenborg, & Ter Kuile, 1996; Wouda, Hartman, Bakker, Bakker, & van de Wiel, 1998). Although a thorough review of this literature is not within the scope of this critique, all phases of the sexual response cycle are clearly affected by the experience of pain during intercourse. This is consistent with clinical reports of women suffering from dyspareunia, who frequently describe not only a decrease in pleasure during penile insertion or thrusting, but also a co-morbid decrease in sexual desire for a wide range of non-penetrative activities and a more general sense of disconnection with their sexuality. Therefore, the current classification of dyspareunia does not reflect a lack of fit with sexual impairment, but rather, an overarching impact on the sexual response cycle which cannot be limited to one phase in particular. Dyspareunia is also unique from other pain disorders given this profound impact on sexual functioning. While one could argue that many different pains can interfere with sexual functioning (such as lower back pain inhibiting some sexual positions), it is unlikely that other pains will have the same devastating impact on sexuality given the location of the pain in dyspareunia.

Given that dyspareunia has such a tremendous impact on all aspects of sexual functioning, it is a particularly suitable candidate for the category of sexual dysfunction; however, Binik further argues that the major symptom in dyspareunia is the pain rather than the interference with sexual intercourse. Supporting this notion, Binik raises the important point that women with dyspareunia experience pain in non-sexual contexts as well. Certainly, an important theoretical issue for the classification of

mental disorders is, "What constitutes a major symptom?" Traditionally, this has been identified as the patient's chief complaint and failing that, the chief complaint as deemed by others in the patient's environment. Binik also raises the important point that classifying a dysfunction according to the activities with which it interferes does not constitute a valid clinical entity. However, what happens in instances where the interference is the chief complaint? Take the case of agoraphobia or social phobia, where the major symptom could be argued to be anxiety. These diagnostic categories emphasize an impaired activity such as leaving the home or engaging in social interaction. As with dyspareunia, the anxiety felt by these patients no doubt interferes with other activities as well; however, their chief complaint (and thus the "major symptom") has been defined behaviorally. It has been my experience that most women suffering from dyspareunia seek treatment due to the inability to engage in intercourse rather than the pain per se. Tampons and tight jeans can be avoided; however, the act of sexual intercourse is so highly valued in our society that these women often feel defective and sexually inadequate. To classify their pain as a Pain Disorder alone would be to deny their true experience of this condition.

I have made the argument thus far that dyspareunia is a sexual dysfunction; however, dyspareunia also meets diagnostic criteria for a Pain Disorder if not for being specifically excluded. Binik fears this sends the message that there are two kinds of pain in the world: those that are sexual and those that are not. This is a valid concern. If the current DSM classification system leads health professionals to believe that the pain of dyspareunia is somewhat less "real" or not worthy of concern or treatment independent of addressing sexual or couple functioning, this would be a mistake. Therefore, I recommend a dual coding whereby urogenital pain may be coded under Pain Disorder as Binik suggests, with or without dyspareunia, thereby retaining a coding under the sexual dysfunctions reflecting the very unique and sexual implications of this pain. Likewise, though various mental disorders in the DSM share many aspects in common, more diagnostic information is retained by coding these separately when co-morbid.

Binik also raises the issue of treatment. If pain treatment approaches are more effective than sex therapy in treating dyspareunia, it should then be classified under the category of Pain Disorder to capture the attention of the appropriate clinicians and encourage relevant treatment strategies. However, within his thorough review, Binik only illustrated that the addition of pain-management techniques to sex therapy in a group therapy treatment plan as done by Bergeron, Binik, Khalifé, Pagidas, and Glazer (2001) has empirical support for the treatment of vulvar vestibulitis syndrome. To date, no one has compared sex therapy to pain management techniques in a randomized treatment outcome trial and this is unlikely ever to be done. Binik raises a worthy concern that pain management techniques should be integrated into traditional sex therapy approaches for the treatment of dyspareunia. Thus, it would be beneficial that sex therapists work in conjunction with these professionals and/or adopt some of these techniques themselves. In this respect, I feel dyspareunia should also remain under the category of Sexual Dysfunctions lest medical professionals attempt to treat the pain without addressing sexuality. Although this can be beneficial for pain reduction as in the case of vestibulectomy (see Bergeron, Binik, Khalifé, & Pagidas, 1997), research has shown that simply reducing the pain does not necessarily result in an improvement in sexual functioning (Bergeron et al., 2001).

Finally, Binik highlights the profound influence our conceptual models can have on research. The conceptualization of dyspareunia as a Pain Disorder has inspired much work on the pain component of "painful sex" emerging from his laboratory (Pukall, Payne, Binik, & Khalifé, 2003). This work has served to improve our understanding of these conditions (particularly vulvar vestibulitis syndrome) and will no doubt continue to do so. However, with the exception of the measurement of sexual dysfunction, one cannot help but notice the relative scarcity of knowledge on the sexual component of dyspareunia. Binik aptly notes this neglect within the literature, particularly when addressing the question of whether the physical and psychosocial correlates of dyspareunia are more relevant to pain or to sex. Similarly, Binik also notes the absence of a theoretical model for the classification of dyspareunia as a sexual dysfunction. Therefore, dyspareunia should be maintained under the sexual dysfunctions in the hopes of promoting research on this highly relevant component.

Most recently, I have completed a study examining the cognitive processing of pain in a sample of women suffering from vulvar vestibulitis syndrome and matched healthy control women (Payne, Binik, Amsel, & Khalifé, 2005; in press). The results of this study suggested that women with vulvar vestibulitis exhibit an attentional bias for pain stimuli predicted by anxiety and fear of pain. In addition to exacerbating the salience of pain, this attentional bias may also serve to distract from sexual stimuli during sexual activity. Similarly, Barlow (1986) has suggested that in men with erectile dysfunction anxiety produces a focus on task-irrelevant stimuli such as concerns regarding non-performance. This is theorized to produce a distraction away from sexual stimuli resulting

in impaired sexual arousal. A similar process could be occurring in women with dyspareunia. That is, the anticipation of pain may be triggering an off-task focus on pain and related concerns about non-performance, resulting in less attention to erotic cues and impaired sexual arousal, possibly further exacerbating the pain experience. Certainly, it is not uncommon for women with dyspareunia to recount an incident or a one-night-stand where they were so sexually aroused that they did not feel the pain. Research examining the relationship between sexual arousal and pain perception is currently underway. However, these tentative speculations pave the way for further research into the sexual component of dyspareunia which may itself have important implications for diagnostic classification.

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A More Radical Proposal: Dyspareunia Is Not a Mental Disorder

Robert L. Spitzer, M.D.
Biometrics Research Department, Unit 60, New York State Psychiatric Institute, 1051 Riverside Dr., New York, New York 10032-2695; e-mail: rls8@columbia.edu.

Binik usefully reviews the history of the classification and conceptualization of dyspareunia. He shows how historically the term has implied the etiologic role of psychological factors. To me, he provides compelling evidence that it makes no sense to continue to classify dyspareunia as a sexual dysfunction. Instead, he proposes that in the DSM it be classified as a "sexual pain disorder," claiming that it meets the criteria for a DSM pain disorder. Does it? Criterion C of a DSM-IV Pain Disorder is: *Psychological factors are judged to have an important role in the onset, severity, exacerbation or maintenance of the pain.*

I find it puzzling that Binik, having rejected the historic meaning of the term which emphasized the central etiologic role of psychological factors, apparently believes that this criterion applies to dyspareunia. He certainly does not believe that there is evidence that psychological factors are related to the *onset* of dyspareunia. He provides no evidence that psychological factors play a more prominent role in the *severity, exacerbation or maintenance* of dyspareunia than they do in many general medical disorders. He shows how the treatment and management of dyspareunia should focus on the pain and how little mental health expertise has to offer. This leads to only one conclusion: dyspareunia should no longer be classified as a mental disorder, but instead should be classified as a general medical disorder. I ask Binik: Why not?

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A Rose by Any Other Name: Should Dyspareunia Be Reclassified?

Donald S. Strassberg, Ph.D.
Department of Psychology, 580 S. 1530 E., Room 502, University of Utah, Salt Lake City, Utah 84112; e-mail: donald.strassberg@psych.utah.edu/

In his well written and thoughtful article, Binik argues persuasively that dyspareunia should be classified (primarily in the DSM) as a pain disorder (based on its primary symptom of genital pain) rather than as its current classification, a sexual disorder (by virtue of its disruption of normal sexual functioning). Obviously, both features of the disorder are important, but Binik offers many reasons why pain, not sex, should be the overriding organizing element.

It seems to me that while some elements of Binik's case are quite strong, others are less so and detract from his overall argument. Further, while it could be viewed as the main focus of his article, for me the issue of whether or not the DSM should re-categorize dyspareunia seems far less important than how we think about and treat this important and difficult clinical problem.

Binik and his colleagues are to be congratulated for advancing our understanding of the nature of at least one important type of dyspareunia, vulvar vestibulitis syndrome (VVS). The finding that VVS may be associated with non-genital sensory functioning is particularly important, as is the development of the vulvalgesiometer, an important new tool both for research and clinical practice. He clearly makes the case for separating VVS from other types of dyspareunia, as has been done with vaginismus. But it is not clear whether their findings regarding VVS, which form the basis of many of Binik's arguments regarding reclassification, apply to any of the other types of dyspareunia. This aside, let me examine some of Binik's arguments in favor of reclassifying dyspareunia as a pain disorder rather then a sexual disorder.

Binik fairly points out that (1) pain is a primary complaint of those presenting with dyspareunia, (2) the pain of dyspareunia can often be evidenced outside of sexual contexts (e.g., with tampon insertion), (3) brain pain centers register some types of dyspareunia in a manner similar to other types of pain, and (4) treatment of dyspareunia using techniques designed for more typical sexual dysfunctions (e.g., secondary erectile dysfunction) has not been highly successful. But are these reason enough to change how dyspareunia should be categorized in the DSM? If not, what about the other arguments made by Binik?

Binik implies that the relative lack of research on dyspareunia is largely a consequence of its current categorization, yet the validity of this assertion is far from

clear. There are many reasons why some disorders get the clinical or research attention they may deserve, while others do not. At best, the label used for categorizing a disorder is only one (and probably not a very strong one at that) such reason. He also argues that if dyspareunia was viewed more like other pain disorders, treating clinicians would focus more on the pain and would be more integrative in their treatment. I believe it is likely that most clinicians treating dyspareunia (e.g., gynecologists, sex therapists) are already far more focused on the pain than Binik gives them credit for. Further, non-medical clinicians have often shown a willingness to broaden the treatment options (e.g., beyond psychotherapy or sex therapy) for sexual disorders (e.g., erectile dysfunction and premature ejaculation) when medical advances in their treatment have become apparent (Strassberg, 1994).

It is also far from a given that pain specialists will prove to be more integrative or more successful in treating dyspareunia than gynecologists or sex therapists have proven to be. I would argue that current treatment of other pain disorders is often far less integrative than Binik suggests. Outside of multimodal pain clinics (which, on a large scale, are a relatively recent phenomenon), much pain treatment is still quite discipline specific. For example, in the case of chronic back pain, you have chiropractors suggesting spinal adjustments, internists prescribing drugs, surgeons offering surgery, physical therapists doing their thing, and psychotherapists teaching relaxation training and self-hypnosis. In many (most?) such cases, a practitioner will involve other specialists only when their approach has failed.

Calling for a broader view of dyspareunia, especially VVS, makes very good sense, especially in light of Binik's research. But is it critical to this movement that we ignore or downplay the very critical impact dyspareunia has on sexual functioning? In my experience, it is this feature of the disorder that is usually responsible for the woman seeking treatment, usually often only after having lived (along with her partner) with the problem for years. As a result, it is often (usually?) advantageous to include some type of couple's counseling as part of the assessment and treatment of the disorder. One possible advantage to keeping dyspareunia categorized as a sexual (as opposed to a pain) disorder in DSM is that it could encourage treatment providers to consider the sexual (both individual and dyadic) implications of the problem and its treatment. In recent years, we have learned that physicians and others sometimes need to be encouraged to consider more than symptom removal as part of the treatment of sexual disorders (Strassberg, 1994; Tiefer, 1994).

From my perspective, things sum up as follows. Binik and his colleagues have added immeasurably to our understanding of dyspareunia, particularly a major subgroup of those with this disorder: women with VVS. He clearly has a case for moving dyspareunia (or at least VVS) out of the DSM category of sexual disorder and into the category of pain disorders (e.g., genital, or genitourinary pain disorder). But to me, the case doesn't seem as strong or as one-sided as he wishes to portray it. In particular, I don't believe he has made the case that clinical approaches to the condition or research into its etiology, nature, or treatment have been significantly hampered specifically because of the DSM category under which the disorder has appeared, nor that treatment and research of the condition would be dramatically improved by a category change. Certainly, the movement over the years in the DSM treatment of homosexuality (i.e., from always a disorder, to only a disorder if the person doesn't want to be homosexual [i.e., ego-dystonic homosexuality], to [virtually] no longer a disorder) has, in and of itself, probably changed the minds or approaches of very few clinicians or researchers.

I believe that the most likely reason for a change in the way dyspareunia is approached by most clinicians or researchers will be the programmatic, careful, and creative work of a few researchers such as Binik. For this, he should be applauded. Has Binik, in this article, made a reasonable case for at least the consideration of changing how the DSM or other diagnostic systems treat VVS and other forms of dyspareunia? I think he has. Is the case as much a "no-brainer" as he seems inclined to try to make it? I don't believe so. Would such a change necessarily be a good thing? This seems far from clear, but maybe. Still, the change seems worth considering.

Much more importantly, however, Binik has made clear that we need to develop a better understanding of the etiology, nature, and treatment of dyspareunia. This can, and should, happen whether or not the disorder, or its subcategories, changes location in the DSM or anywhere else. "A rose by any other name . . . "

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Dyspareunia Is the Only Valid Sexual Dysfunction and Certainly the Only Important One

Leonore Tiefer, Ph.D.
Department of Psychiatry, New York University School of Medicine, 163 Third Ave., #183, New York, New York 10003; e-mail: LTiefer@mindspring.com.

I have spilled gallons of ink over many years criticizing the sexual dysfunction nomenclature in the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association as it applies to women (Tiefer, 1988, 1991,

1992, 1996, 2004). I believe it was a mistake for the American Psychiatric Association (1980) to base a normative model for women's sexuality on physiological research wherein Masters and Johnson (1966) described a universal "human sexual response cycle." Masters and Johnson (1966) had used a highly selective sample in their research and in addition had coached their participants. The resulting normative cycle was inconsistent with what decades of feminist research had shown to be a highly diverse range of women's sexual responses in response to culture and circumstances.

The genital-performance focus of the *DSM* nomenclature lent itself to a reductionist view of sexual satisfaction and experience that was easily hijacked by the pharmaceutical industry when, following the blockbuster launch of Viagra in 1998, it went looking for an approach to women's sexual problems that would support the promotion of genitally-acting drugs for women (Basson et al., 2000; Tiefer, 2001).

In response to the inadequacies of the *DSM* nomenclature (and in despair over the new industry involvement), I convened a multidisciplinary Working Group on "A New View of Women's Sexual Problems" in 2000. We drafted a document that offered an alternative system of classification we have used as the basis of an activist educational campaign about the dangers of medicalizing women's sexual problems (Kaschak & Tiefer, 2001; http://www.fsd-alert.org/ manifesto.html). So, I am no fan of the current *DSM* nomenclature, and have probably done as much as anyone to analyze its flaws and offer other perspectives.

My criticisms have, however, focused on the universalized notions of desire, arousal, and orgasm in dysfunction nomenclature, and not on the inclusion of dyspareunia and sexual pain. Immersed in the feminist literature on women's health, I was more than aware of the disgraceful history of neglect and mishandling of women's complaints of pelvic pain and thus it seemed that dyspareunia was *the only* sexual dysfunction with validity in women's lives.

Sources of Sexuality Nomenclature

The *DSM* view of sexual dysfunction is based on the widespread cultural norm that sexual function, for both men and women, consists in being able to perform heterosexual intercourse. The cultural norm itself, of course, is not explicitly stated. Rather, we see the norm assumed in and refracted through the research of Masters and Johnson (1966) and the clinical addenda of psychiatrists Kaplan (1977) and Lief (1977). Contemporary norms require not only that sexually healthy people perform sexual intercourse but experience desire for it and perform it with control and enjoyment, and the clinical nomenclature reflects those changes.

Of course, in clinical texts, these socially constructed and evolving *cultural* norms are presented as universal *clinical* norms, as if scientific research had uncovered some bedrock sexual nature based in biology and derived from evolution. The assumption that there is a universal human blueprint for sexual function is essential for defining variations as "dysfunctional," i.e., clinically abnormal, despite the global and gendered variation in sexual preferences, scripts and satisfactions.

Uses of Sexuality Nomenclature

The development of *DSM* nomenclature for sexual function and dysfunction served a variety of professional and social needs. Irvine (1990) argued that conceptualizing sexuality within a medical framework generated respectability, professional legitimacy, and financial opportunity for physicians and sexologists. Taking a larger perspective, classifying sexual problems within a medical framework offered moral legitimacy, i.e., permission, for pleasurable sex in an era when, especially for women, the entitlement to sexual pleasure was only beginning to be accepted. Classification legitimized clinical inquiry and treatment, professional education, health insurance coverage, and research attention. Anyone who contemplates revisions of sexuality nomenclature must not forget that such systems serve various purposes for multiple audiences, and have an impact on policy and social values as well as clinical practice.

History of Women and Sexual Pain

Looked at from this perspective, the inclusion of women's problems with sexual pain in the sexual dysfunction classification system was a positive step. Professional organizations (e.g., International Society for Vulvovaginal Diseases; http://www.issvd.org) and patient advocacy organizations (e.g., National Vulvodynia Association; http://www.nva.org) use the official recognition to encourage public awareness, research, better medical treatment, and insurance coverage.

The support is extremely important, as there is no shortage of evidence that the experience of unwanted pain during sexual relations is common, poorly managed, and creates great personal and marital misery (http://www.nva.org/nva_newsletter/harlow.html). Beyond women's lack of sexual satisfaction or lack of orgasms, the common experience of pain during intercourse or vaginal penetration lies at the heart of the feminist critique of patriarchal sexual relations (e.g., Boston

Women's Health Collective, 1998, pp. 256–257). Feminist sex therapists have repeatedly called for downplaying the importance of coitus because of the prevalence of sexual pain (Kleinplatz, 2001; McCormick, 1994). Ironically, as if to embrace this feminist view, the newest addition to clinical listings is "noncoital sexual pain disorder" (Basson et al., 2000, p. 890). Coitus-related pain, however, remains primary.

Although the phrase "sexual pain" does not appear in the Declaration of Sexual Rights of the World Association of Sexology (http://www.tc.umn.edu/~colem001/was/wdeclara.htm), it is implicit in the emphasis on the rights to bodily integrity, sexual pleasure, and autonomy. The promotion of the "right to sexual health care" as a public health issue will do a great deal to eradicate women's global burden of sexual pain.

Sexuality Nomenclature as Sexual Politics

Binik argues here and in numerous other places that "sexual pain disorder" makes no sense because "there is no special type of pain that is sexual in nature" and that sexual pain should become a subcategory of "pain disorders." But this represents a misunderstanding both of what constitutes a sexual problem and of the role of professional nomenclature.

As the multidisciplinary "Working Group" stated in its manifesto, "Sexual problems [are best defined] as discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience" (Kaschak & Tiefer, 2001, p. 5; http://www.fsd-alert.org/manifesto.html). We recommended that professional nomenclature dispense with the idea of norms and deviance, a truly radical paradigm shift, and move to a model wherein sexuality was viewed as a cultural construct and individuals could have various subjective or performance problems. Thus, sexual pain would be like swimming pain or swimming phobia, a problem that a person had with a desired behavior, not with some universal capacity.

As long as there are expert-based listings of sexual dysfunctions, we do women a disservice by failing to include pain as one of them. Of course, I'm more than happy to dispense with such norms entirely.

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Pain or Sex?: Choosing the Best Option

John M. Townsend, Ph.D.
Department of Anthropology, Syracuse University, Syracuse, New York 13244-1090; e-mail: JMTSU44@aol.com.

Binik presents a solid case for the reclassification of dyspareunia as a pain disorder: the current DSM designation of dyspareunia as a sexual dysfunction lacks both empirical support and a theoretical rationale. Binik also argues that reclassification has important clinical, social, and political implications. I will comment and elaborate on some of these implications.

Binik notes that there are no validated criteria to support the current differentiation of dyspareunia into "organic/due to a medical condition/psychogenic/combined factors." In practice, psychogenic dyspareunia is diagnosed when relevant organic factors are excluded, but no formal criteria, data, or procedures allow the systematic exclusion of organic factors. Similarly, the literature on psychosocial correlates of dyspareunia is spotty and contradictory. In some studies, women who suffer from VVS also exhibit higher levels of multifarious symptoms, including anxiety, hypervigilance, depression, somatic complaints, and marital distress. Although some experts have suggested a biopsychosocial approach to the treatment of sexual dysfunction, the practical result has been a "serial undisciplinary" strategy starting with medical interventions, followed by psychotherapy/sex therapy, and, then, possibly surgery. Binik documents that this strategy has not been generally successful.

The psychological and psychosomatic correlates of dyspareunia resemble those of menopausal syndrome: they are highly variable, diverse, amorphous, and not reliably demonstrable. In these aspects, the psychological and psychosomatic correlates of both disorders, dyspareunia and menopausal syndrome, resemble the symptoms of some of the folk-illnesses described in the medical-anthropological literature (Townsend, 1980). When general complaints such as these are not tied to any demonstrable organic cause, they are especially vulnerable to the impact of social factors that shape illness behavior. Admittedly, all symptoms of disease that become organized into illness behavior do so through a process of negotiation. The impact of sociocultural factors, however, on this "construction of clinical reality" (Kleinman, 1988; Kleinman, Eisenberg, & Good, 1978) is most pronounced when symptoms are relatively amorphous, diverse, and ambiguous (Townsend, 1978, 1982). Clinicians often play a crucial role in this process.

In a pioneering study of symptom variation, Donovan (1951) found that the method of clinical history-taking places disproportionate emphasis on the symptoms to which the physician directs the patient's attention. Donovan, over a period of several months, repeatedly interviewed women who were diagnosed by physicians as suffering from "menopausal syndrome." Of these women, 95 percent appeared to be highly suggestible and had had a series of similar complaints *before* menopause. Donovan concluded that symptoms of emotional stress

occurred with menopause only if there had been a past history of emotional problems, and that considerable variability appeared in the reporting of symptoms in different interviews with the same woman.

Similarly, in a sample of 250 questionnaires collected and analyzed by the Woman in Midstream group, although only about 60 percent of the sample sought medical treatment for organic symptoms of the climacteric from their family physicians or gynecologists, 75 percent received estrogen therapy. For 11 percent, no treatment was prescribed and for 9 percent psychiatric therapy was recommended. The most alarming finding was that 55 percent received prescriptions for psychotropic medications (Bart & Grossman, 1976). More recent studies suggest that gender stereotypes continue to affect both primary care and psychiatric practice (Cleary, Burns, & Nycz, 1990; Redman, Webb, Hennrikus, Gordon, & Sanson-Fisher, 1991; Townsend, 1995).

Binik notes that dyspareunia is rare among men, and relevant literature is scant. This raises the question of whether pain associated with prostate disorders, which frequently interferes with intercourse, is diagnosed as dyspareunia. I suspect not for the following reasons: (1) an organic cause is obvious; (2) an implicit assumption operates that dyspareunia is not a male disorder and therefore the pain in male patients cannot represent dyspareunia; (3) the stereotype operates that women are more likely than men to invent excuses in order to avoid intercourse (Binik's classic "Not tonight dear, I have a headache"); male pain is "real" and therefore not diagnosed as dyspareunia. Certainly, the fact that the original classification of dyspareunia was made by a Victorian male and focused on *interference* with coitus is consistent with this interpretation. To be sure, some statistical reality underlies this stereotype: the average male continues to complain about coital infrequency more than the average female (Townsend, 1998). The image, however, of women avoiding intercourse through psychological and psychosomatic complaints should not be allowed to affect the diagnosis and treatment of urogenital pain.

Under Binik's proposed reclassification, gender stereotypes are less likely to influence research, diagnosis, and treatment. For example, when researchers focused on pain and the specific diagnosis of VVS, patients were more sensitive than controls to pain in other areas of their bodies as well as the genitalia; in fact, the patients' touch threshold was equivalent to the controls' pain threshold. Without this focus on pain, and the sophisticated methods for measuring it, these patients could have been viewed as suffering from psychological disorders, or, worse, as simply examples of women who don't like sex.

Twenty-five years ago, Utian (1979), an endocrinologist, argued that the diagnosis of menopausal syndrome should be restricted to those organic changes directly and empirically related to estrogen insufficiency: amenorrhea, hot flushes, and vaginal atrophy. A host of other symptoms that are commonly listed as components of climacteric syndrome are not empirically associated with estrogen lack and should therefore be excluded (e.g., anxiety, depression, frigidity, and irritability). Furthermore, Utian argued that these indices were too vague and imprecise to play any meaningful role in the pharmacologic evaluation and physiologic characterization of patients, and that they should therefore be dropped from clinical practice. Binik makes a similar case for a refocus on pain, which is certainly a more objectively measurable symptom than interference with an activity. Thus, for both dyspareunia and menopausal syndrome, the restriction of criteria and focus allows researchers to draw on a solid corpus of research on physiologic manifestations and correlates, and enables clinicians to diagnose more reliably, and presumably, to treat more effectively. For these reasons, the reclassification is a sound idea and long overdue.

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Sexual Dysfunction or Pain Disorder?: Dyspareunia from the Perspective of the Harmful Dysfunction Analysis

Jerome C. Wakefield, D.S.W., Ph.D.
New York University School of Social Work, 1 Washington Square North, New York, New York 10003; e-mail: Jerome.Wakefield@nyu.edu.

Clarifying the Question

Is dyspareunia (painful sexual intercourse) a sexual dysfunction or a pain disorder? Binik argues vigorously for the latter conclusion (see also Binik et al., 2002; Meana et al., 1999b). To many, this may look like a false dichotomy or a distinction that makes no difference; however, from the perspective of the harmful dysfunction (HD) analysis of the concept of disorder (Wakefield, 1992, 1999), I agree with Binik that the question is conceptually meaningful. The HD analysis holds that a harmful condition is a disorder if and only if it is caused by a dysfunction in the individual (i.e., inability of some internal mechanism to perform a biologically designed function). Thus, the super-ordinate category (e.g., "pain disorder" versus "sexual dysfunction") under which a specific DSM disorder category is placed can matter because it can indicate the kinds of mechanisms and functions that have failed. Thus, for example, anxiety

disorders are conditions inferred to be due to dysfunctions of one sort or another in mental mechanisms biologically designed to generate and regulate anxiety.

It is underlying dysfunctions that generally define disorders; two superficially similar conditions may be classified as different disorders if they are found to be generated by different underlying dysfunctions, and two superficially different conditions may be classified as variants of the same disorder if they result from the same underlying dysfunction. Many disorders involve multiple levels of dysfunction, and generally disorders are identified by the deepest level dysfunction from which the rest result, if there is one. In the case of dyspareunia, it is clear that there is syndromal harm both in the form of pain and in the form of inhibited or less pleasurable sexual functioning. So, Binik's claim that dyspareunia is really a pain disorder makes the most sense when posed as a claim about what is the deepest level of dysfunction that can plausibly be inferred to underlie conditions currently classified as dyspareunia.

If this approach is accepted, then what may appear to be a pointless classificatory question can be translated into a potentially interesting conceptual/theoretical question: Is dyspareunia a failure of function of sexual mechanisms or of pain mechanisms (or both or neither)? I think this is not far from the way that Binik implicitly construes his question, but in any event this is how I shall construe the question.

There are two sources of information to resolve this question. One is the logic of the diagnostic criteria themselves. The other is recent factual evidence and theoretical developments concerning the conditions currently considered dyspareunia, reviewed by Binik in the target article. I explore both in my comments below.

Why Binik's Arguments Are Not Persuasive

Binik presents a great variety of practical and theoretical arguments for reclassifying dyspareunia under pain disorders. Before considering the issue on its merits, I indicate why I find his arguments unpersuasive. Yes, treatment of dyspareunia may involve management of pain, but it may also involve management of sexual interaction to minimize discomfort and allow for sexual satisfaction (Binik notes that reducing pain does not necessarily bring sexual activity back to normal, underscoring this point). Yes, techniques used to treat pain disorders may be useful in treating dyspareunia, but that does not mean that the condition is a pain disorder, nor does diagnostic category determine or limit the kind of treatment one can pursue. Yes, dyspareunia pain is similar qualitatively to other pain, leaves a "pain signature" in the brain, and can be characterized using the usual dimensions for describing pain (e.g., temporal occurrence and spatial location), but that just follows tautologically from the fact that it is pain, and nothing follows from this about whether it is a pain disorder (most pain is not a pain disorder). Yes, including such details as specific location within the genital region and temporal triggering during sexual activity leads to better predictive validity regarding certain categories of physical problems over and above what is predictable from DSM criteria for dyspareunia alone; however, such additional information should be expected to yield added validity irrespective of how the conditions are classified, and the same information would have to be added to DSM pain disorders as well because such information is *not* included under the DSM "pain disorder" diagnostic coding, which just specifies the general anatomical region (e.g., "genital"). Yes, the evidence is that DSM dyspareunia is not a unitary disorder and lacks face validity as a unitary construct, but that is true of many DSM categories by the very nature of the syndromal approach, and it is true also of DSM genital pain disorder.

One of Binik's main arguments is that, contrary to DSM criteria, the pain in conditions classified as dyspareunia is not in fact "associated with intercourse." Here, as elsewhere, Binik tends to write in generalizations as though all cases are the same, rather than drawing distinctions between subtypes. As a generalization, Binik's assertion, which relies on Meana's (1999) study, is misleading. Of a sample of women presenting with pain during intercourse, only about one-fifth reported pain from each of the following three non-intercourse circumstances: friction with clothing, urination, and manual stimulation (these are probably mostly cases of VVS, to which I return later). The "non-intercourse" pain referred to by Binik that is experienced by larger numbers of women consisted of pain experienced from other forms of vaginal penetration, including finger insertion (almost half the women), gynecological exam (about two-thirds), and tampon insertion (about one-third). These all involve vaginal penetration in ways not biologically designed. It would seem that in the sense intended by the DSM, these facts are consistent with the DSM requirement that the pain be "associated with intercourse," which is intended to apply to interference with sexually designed functioning. In any event, if the criteria were changed to "associated with vaginal penetration," a necessary prerequisite for intercourse, nothing would be lost and the supposed exceptions eliminated.

In response to the objection that the diagnosis of dyspareunia is analogous to accepted diagnostic categories

such as dyspepsia and dysmenorrhea, Binik argues, first, that these other categories are not useful because they lump together different sources of pain. But such syndromal categories that lump together diverse underlying dysfunctions are useful as long as we lack conclusive knowledge of specific etiologies and need some way of identifying a domain of dysfunctions on the basis of their superficial effects, and Binik himself states that "we know little about etiology." Transferring conditions en masse from dyspareunia to pain disorder without such an understanding would be premature. Second, Binik argues that the analogy between dyspareunia and these other conditions is logically faulty because, whereas both dyspepsia and dysmenorrhea refer to pain associated with a physiological process, dyspareunia refers to pain associated with an interpersonal behavior. But, certain behaviors are part of our biologically designed capacities, and when the capacity is impaired there is just as much a dysfunction as when a physiological process is impaired. Stuttering, for example, is a genuine disorder even though the dysfunction involves incapacity of speech behavior. The analogy is indeed logically faulty, but for an entirely different reason–dyspepsia and dysmenorrhea do not necessarily interfere with the digestive or menstrual functions, respectively, but rather are painful effects of those processes (note, however, that they are commonly classified not as pain disorders but as digestive and gynecological problems). In contrast, dyspareunia actually does interfere with the capacity to engage in and enjoy intercourse, a biological function of the sexual organs. Thus, if anything, the disanalogy argues for the greater sense in identifying dyspareunia versus the others as a functional disorder.

In a similar vein, Binik argues that intercourse itself is not part of the standard sexual response cycle of desire-arousal-orgasm; thus, interference with intercourse is not a sexual dysfunction. But surely the entire cycle is biologically designed at least in part to create the capacity for, bring about, and coordinate with intercourse and to allow a capacity for pleasurable intercourse. Why else do women have mechanisms for lubrication or a vulvar vestibule that allows penetration? So, when Binik states that "dyspareunia is not linked to, and does not interfere specifically with, any stage of the sexual response cycle," this is manifestly false. The function of pleasure or at least lack of substantial pain under standard coital conditions is implicitly part of sexual functioning. The capacity for penetration and intercourse with pleasure is an integral part of the sexual response cycle from a biological functional standpoint.

The Functional Logic of DSM Diagnostic Criteria for Dyspareunia

An examination of the current DSM criteria for dyspareunia from a harmful-dysfunction perspective underscores the functional nature of the concept. I focus here on Criterion A, "recurrent or persistent genital pain associated with sexual intercourse in either a male or a female." Criterion B, the "clinical significance" criterion, is of a kind that I (Spitzer & Wakefield, 1999) have critiqued elsewhere as redundant; in this case, abnormal pain during intercourse is a disorder irrespective of whether one is distressed about it or whether one gets into interpersonal difficulty over it.

In Criterion A, "sexual intercourse" is intended to refer only to genital-genital intercourse. There is a good explanation for this limitation, from the perspective of the HD analysis. Only genital-genital intercourse represents a sexual process that we believe to be biologically designed and (we believe) designed to occur without substantial pain. The same cannot be said for other forms of sexual intercourse. There is no clear evolutionary rationale as to why, say, vigorous digital probing of the vagina might not cause some pain. Fellatio can be painful either when teeth impact the penis or when penile penetration of the oral orifice is too vigorous or deep, but no one thinks that such pain represents a disorder, even if it occurs regularly due to the lack of skill or other features of the participants. In contrast to genital-genital intercourse in which structures are specifically designed for that function, other forms of sex, however natural the desire, exploit bodily structures not obviously designed for such use. (Of course, such beliefs are open to challenge, as in the comment that it cannot be accidental that our hands hang at just the right height to facilitate masturbation.)

This is not merely a theoretical issue. There are attempts to extend dyspareunia to other than genital-genital intercourse, and there is especially a certain impetus to doing so given the depathologization of homosexuality. For example, unsurprisingly, pain is not uncommon during receptive anal intercourse (Rosser, Short, Thurmes, & Coleman, 1998). It has recently been proposed that the category "anodyspareunia," denoting painful receptive anal intercourse, be defined using clinical criteria similar to those for the current category of dyspareunia. Although such pain may pose a relationship challenge and thus a problem in living for some, the HD analysis suggests that it makes no sense to consider it a disorder, however useful it may be to direct clinical intervention to its relief. Of course, if there are psychological dysfunctions involved in the cause, exacerbation, or maintenance of such pain, that would be a different story.

Even in genital-genital intercourse, there are many non-pathological sources of pain that could incorrectly fall under Criterion A. From some studies, it appears that many women, perhaps most, experience some incidental pain during intercourse. Some couples engage in sexual positions or activities that can easily or even expectably create some pain, such as vigorous pounding-style thrusting or entry at an unusual and potentially painful angle. Such pain, even if recurrent because of preferred sexual practices, is not a disorder. There are also basic mismatches (e.g., in genital size) that may result in pain. Note that while 70% of Meana's (1999) sample of women reporting painful intercourse reported having pain with all partners, thus likely excluding many situational or relationship etiologies, 30% did not. About 10% of the women in Meana's (1999) study attributed their pain to either a mismatch in genital size (vagina too tight or penis too large) or problematic love-making techniques, and there is no particular reason to doubt all these self-diagnoses. In such cases, the woman has neither a sexual nor a pain disorder, though there is certainly a problem. Finding ways for the criteria to exclude such non-pathological causes of recurrent pain might help increase validity.

The moral of these comments is that intuitions about what is and is not the disorder of dyspareunia follow a functional logic based on how we think the sexual organs are biologically designed to function during intercourse. Thus, there is nothing wrong, all else being equal, with specifying a dysfunction in terms of interference with the intercourse function of the vagina due to abnormal pain. (Of course, Binik would argue that all else is not equal because in fact there is a known deeper pain dysfunction of which the genital pain during intercourse is just an incidental result.) Surely one can at least say that there is such a sexual dysfunction "secondary to" some other, deeper disorder that generates pain when intercourse is attempted. Whether Binik is correct that there exists a pain disorder is to be considered presently.

Probable Etiologies of Dyspareunia

In assessing Binik's classificatory argument, one needs to keep in mind what is known or at least tentatively believed about the etiology of pathological genital pain during intercourse. In an exhaustive assessment of 112 women with dyspareunia that included three different gynecological examinations, Meana et al. (1997) found that the women fell into four groups (although Binik notes that the actual situation appears to be more complex), of which three appeared physically based: 46% suffered from vulvar vestibulitis (VVS: heightened touch and pain sensitivity, and severe pain, tenderness, and inflammation of the vulvar vestibule when touched or rubbed, often involving a burning-like or cutting-like sensation; thought to be a variety of vulvodynia); 13% suffered from vaginal atrophy (usually estrogen-deficiency induced); and 17% suffered from other physical causes (e.g., prolapsed uterus, endometriosis).

Binik places particular emphasis on the approximately half of dyspareunic women with VVS, so the etiology of VVS takes on some importance. There are several theories of VVS, none very compelling. One idea is that it is due to chronic inflammation, but studies suggest that most women have chronic inflammatory reactions in the vulvar area and so the response of those with VVS is not explained. A plausible suggestion is that VVS is a mild form of vulvodynia, a condition typically manifested by a cutting/burning type pain similar to VVS's but one that occurs more continuously; VVS, the theory goes, is a milder form of vulvodynia in which the pain emerges only upon stimulation; however, the etiology of vulvodynia is unknown. Another theory mentioned by Binik was based on Pukall et al.'s (2002) finding that women with VVS are generally more sensitive than controls to tactile and pain stimulation to non-vulvar regions of the skin. Thus, Binik suggests, VVS may involve a general disorder of hypersensitivity to tactile and pain stimuli, in which pain emerges at a lower threshold than usual in the vulva. However, even if lower-than-average sensory thresholds play a role in VVS, no evidence is offered that such below-average thresholds constitute a disorder, and it seems implausible that a general disorder of this kind would give rise to a pain problem in just one area of the body. The one thing that is a reasonable surmise at this point, and is generally agreed, is that VVS and vulvodynia are general medical conditions, as are the conditions underlying pain in the other two categories discussed so far.

The fourth group, comprising 24% of the women, had no dyspareunia-related physical findings whatever. This, of course, does not necessarily imply that the condition is purely functional, but neither do physical findings imply the condition is not partly psychogenic; however, there is a sizable population in whom dyspareunia appears to be unrelated to any of the usual physical causes, raising the question of whether sexual feelings and concerns play a role. The case report literature, while of course challengeable on various scientific grounds, contains persuasive reports of cases of dyspareunia that appear to be directly psychogenic and sexual-conflict related. (For one such case, including an enduring cure through resolution of conflictual sexual feelings, see Eagle [1993].) Given the high prevalence estimates of dyspareunia, even a relatively

small subgroup of this kind would warrant retention of dyspareunia as a "sexual dysfunction" category.

Although acknowledging that etiology is currently not established, and quite aware of the 24% with no physical finding, Binik does clearly believe that physical etiologies of the kind represented by the first three categories represent the likely future of the field: "My prediction is that future research will confirm vulvar vestibulitis as a distinct syndrome and point to the existence of a number of other urogenital pain syndromes which will replace our current discrete categories of dyspareunia and vaginismus." If this prediction turns out to be correct, then there indeed ought to be changes in the DSM. But, leaving aside the prematurity of Binik's proposal, we need to ask: In the event that virtually all cases of dyspareunia do turn out to be of this physical kind, or at least for the conditions that do, is Binik correct that the change should be a shift to pain disorders?

Why Pain Disorder Is Not the Answer

In this section, I argue that Binik is incorrect in suggesting that conditions presently falling under dyspareunia can be better reconceptualized as pain disorders. His claim, when placed within the harmful dysfunction framework, comes down to the following: underlying the interference with sexual function is a deeper dysfunction of pain response.

A pain disorder (again, to follow the HD logic that I think is implicit in Binik's proposal) is a HD of the pain response system. There are many such disorders, including psychogenic, physiogenic, and mixed etiologies of forms of either hypoesthesia or hyperesthesia with respect to the pain response. The DSM criteria for "pain disorder associated with psychological factors" do roughly imply such a dysfunction in virtue of Criterion C, "Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain" (American Psychiatric Association, 2000, p. 503). The criteria for "pain disorder associated with both psychological factors and a general medical condition" also imply dysfunction because they, too, require that psychological factors play a significant (though not exclusive) role in pain generation or maintenance. Of course, psychological factors normally play a role in mediating the intensity of and reaction to pain, due to both individual and cultural meanings. But, if psychological factors have an exclusive or "important" role in creating, increasing, or maintaining physical pain due to idiosyncratic expectancies or meanings that go beyond the usual cultural and individual variations, that is *prima facie* a dysfunction because pain is designed primarily as a physical-based response system in which physical stimulus or lesion roughly determines type and degree of pain. The central involvement of psychological factors in generating pain suggests something has gone wrong with the relationship between psychological and pain mechanisms due to a presumed psychological dysfunction.

Binik's analysis implies that most, if not all, cases of dyspareunia are not psychologically mediated but rather are due to general medical conditions. As defined by the DSM, however, "pain disorder associated with a general medical condition" (PD-GMC) is a conceptually confused category that has no *prima facie* credentials as a disorder at all. Note that I am *not* merely claiming that DSM PD-GMC is a *physical* rather than a *mental* disorder. In the preface to the criteria, the DSM itself explicitly recognizes that the conditions falling under criteria for PD-GMC are not mental disorders: "The following is not considered to be a mental disorder and is included here to facilitate differential diagnosis" (American Psychiatric Association, 2000, p. 503). Rather, my point is that the criteria do not define *any* disorder, mental or physical. Here is what substitutes for criterion C in PD-GMC: "A general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.)" (American Psychiatric Association, 2000, p. 503).

This criterion merely states that the pain must be caused by a general medical condition (GMC). Pain due to a GMC is generally undesirable and often warrants clinical management, but it is not itself a disorder. It is a symptom (indicator) of a disorder, but unlike some symptoms, it does not itself represent a superficial dysfunction caused by a deeper underlying dysfunction, as for example, the boils of chicken pox are both a symptom of the underlying dysfunction caused by the viral invasion of the tissues as well as a dermatological abnormality in their own right. Rather, the pain system is biologically *designed* to cause pain as the normal response to violations of bodily tissue integrity, and such pain, even when severe and deserving of management, is a perfectly normal response. The criteria confuse problematic pain or the need to manage pain with pain disorder, thus implying the absurdity that virtually any medical condition in which pain is a problem worth addressing, from broken arms to heart attacks, also involves a second "pain disorder."

Pain is not the same as pain disorder. The very same chronic abdominal pain may be normal if it is a response to an overly tight belt, a symptom of disorder (but a normal response and not a disorder itself) if a

response to an abdominal injury, and a pain disorder if unrelated in the biologically designed way to any external or internal stimulus but rather a matter of the pain response being somehow abnormally triggered. Legitimate pain disorders form a small minority of the many painful medical conditions that would currently fall under PD-GMC.

It should now be clear that the fact that many instances of dyspareunia, as Binik's research group has characterized and elucidated the condition, fall under "pain disorder" is sheerly a result of faulty, invalid criteria. The majority of cases examined by Binik's group in their recent samples likely have no pain disorder or at least there is no evidence that they do. Rather, they have a variety of general medical conditions that give rise to pain during intercourse, and the evidence suggests that the resulting pain is a normal pain response to the medical conditions and not a disordered pain response in which the pain mechanisms are failing to perform as biologically designed. Vulvar vestibulitis is the premier example.

Conclusion

So, should we reconceptualize dyspareunia as "pain disorders that interfere with sexuality rather than as sexual disorders characterized by pain" (Binik et al., 2002, p. 425)? The promise of the DSM syndromal symptom-based classificatory system is that it will lead to its own demise. It will do this by facilitating cumulative research that will eventually lead to etiological understanding that will yield more construct valid categories of disorder. Thus, it is not unreasonable, as evidence about etiology accumulates, to ask questions like the one posed by Binik, as to whether classificatory changes are warranted. In the case of dyspareunia, however, the etiologies are not yet firmly enough established to warrant such action. Moreover, there seems to be at least a minority of cases that could well involve sexual-conflict etiologies and thus might be best kept as a sexual dysfunction category. Most importantly, the best knowledge we have about the non-sexual etiologies suggests that they are general medical conditions that cause pain as an expectable response and that there is no additional pain disorder. Indeed, the DSM criteria for pain disorder due to a general medical condition are so invalid and confused that nothing should be placed there until the criteria are revised to be more valid indicators of pain disorders. Meanwhile, the best guess is that the kinds of conditions that Binik describes are general medical conditions that cause pain that interferes with basic sexual functioning, and thus these conditions would seem to be classic cases of "sexual dysfunctions secondary to a general medical condition." And, there is no reason to think that in general there are underlying pain disorders mediating between the general medical conditions and the interference with sexual function.

REFERENCES

American Psychiatric Association. (1952). *Diagnostic and statistical manual: Mental disorders*. Washington, DC: Author. [Moser]

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author. [Moser]

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, D.C.: Author. [Kleinplatz, Moser, Tiefer]

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author. [Kleinplatz, Meana, Moser, Payne]

Balint, M. (1968). *The doctor, his patient and the illness*. London: Pitman Medical Publishing. [Black]

Bancroft, J., Loftus, J., & Long, J. S. (2003). Distress about sex: A national survey of women in heterosexual relationships. *Archives of Sexual Behavior*, *32,* 193–209. [Levine]

Barlow, D. H. (1986). The causes of sexual dysfunction: the role of anxiety and cognitive interference. *Journal of Consulting and Clinical Psychology*, *54,* 140–148. [Payne]

Baron, R., Levine, J. D., & Fields, H. L. (1999). Causalgia and reflex sympathetic dystrophy: Does the sympathetic nervous system contribute to the generation of pain? *Muscle Nerve*, *22,* 678–695. [Graziottin]

Baron, R., Schattschneider, J., Binder, A., Siebrecht, D., & Wasner, G. (2002). Relationship between sympathetic vasoconstrictor activity and pain and hyperalgesia in complex regional pain syndromes: A case control study. *Lancet*, *359,* 1655–1660. [Graziottin]

Bart, P., & Grossman, M. (1976). Menopause. *Women and Health*, *1,* 3–11. [Townsend]

Basson, R. (1998). Assessment and management of the couple with an unconsummated marriage. *Journal of the Society of Obstetricians and Gynecologists of Canada*, *20,* 33–42. [Basson]

Basson, R. (2002). Are our definitions of women's desire, arousal, and sexual pain disorders too broad and our definition of orgasmic disorder too narrow? *Journal of Sex & Marital Therapy*, *28,* 289–300. [Carpenter & Anderson]

Basson, R., Berman, J., Burnett, A., Derogatis, L., Ferguson, D., Fourcroy, J., et.al. (2000). Report on the international consensus development conference on female sexual dysfunctions: definitions and classifications. *Journal of Urology*, *163,* 888–893. [Levine, Masheb & Richman, Tiefer]

Basson, R., Leiblum, S. L., Brotto, L., Derogatis, L., Fourcroy, J., Fugl-Meyer, K., et al. (2003). Definitions of women's sexual dysfunctions reconsidered: Advocating expansion and revision. *Journal of Psychosomatic Obstetrics and Gynecology*, *24,* 221–229. [Basson]

Bergeron, S., Binik, Y. M., Khalifé, S., & Pagidas, K. (1997). Vulvar vestibulitis syndrome: A critical review. *Clinical Journal of Pain*, *13,* 27–42. [Graziottin, Payne]

Bergeron, S., Binik, Y. M., Khalifé, S., Pagidas, K., Glazer, H. I., Meana, M., et al. (2001). A randomized comparison of group cognitive-behavioral therapy, surface electroymographic biofeedback, and vestibulectomy in the treatment of dyspareunia resulting from vulvar vestibulitis. *Pain*, *91,* 297–306. [Masheb & Richman, Meana, Payne]

Bergeron, S., Brown, C., Lord, M. J., Oala, M., Binik, Y. M., & Khalifé, S. (2002). Physical therapy for vulvar vestibulitis syndrome:

A retrospective study. *Journal of Sex and Marital Therapy*, *28,* 183–192. [Meana]

Bergeron, S., Khalifé, S., Pagidas, K., Meana, M., Amsel, R., & Binik Y. M. (2001). A randomized comparison of group cognitive-behavioural therapy surface electromyographic biofeedback and vestibulectomy in the treatment of dyspareunia resulting from VVS. *Pain*, *91,* 297–306. [Graziottin]

Bergeron, S., Meana, M., Binik, Y. M., & Khalifé, S. (2003). Painful genital sexual activity. In S. B. Levine, C. B. Risen, & S. E. Althof (Eds.), *The handbook of clinical sexuality for mental health professionals* (pp. 131–152). New York: Brunner/Routledge. [Levine]

Berman, J. R., Berman, L. A., Toler, S. M., Gill, J., & Haughie, S. (2003). Safety and efficacy of sildenafil citrate for the treatment of female sexual arousal disorder: A double-blind, placebo-controlled study. *Journal of Urology*, *170,* 2333–2338. [Levine]

Binik, Y. M., Bergeron, S., & Khalifé, S. (2000). Dyspareunia. In S. R. Leiblum & R. C. Rosen (Eds.), *Principles and practice of sex therapy* (3rd ed., pp. 154–180). New York: Guilford Press. [Carpenter & Anderson]

Binik, Y. M., Reissing, E., Pukall, C., Flory, N., Payne, K. A., & Khalifé, S. (2002). The female sexual pain disorders: Genital pain or sexual dysfunction? *Archives of Sexual Behavior*, *31,* 425–429. [Wakefield]

Black, J. S. (1974). Sex and the gynaecologist. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, *14,* 238–240. [Black]

Black, J. S. (1988). Sexual dysfunction and dyspareunia in the otherwise normal pelvis. *Sexual & Marital Therapy*, *3,* 213–221. [Black]

Black, J. S. (1991). Dyspareunia and vaginismus. In E.-S. Teoh, S. Ratnam, & M. Macnaughton (Eds.), *The current status of gynaecology & obstetrics series*. Vol. 6. *General gynaecology* (pp. 125–132). New York: Parthenon Publishing Group. [Black]

Black, J. S. (2000). Letter responding to Pagano's article on vulvar vestibulitis syndrome. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, *40,* 108–109. [Black]

Bohm-Starke, N., Hilliges, M., Falconer, C., & Rylander, E. (1999). Neurochemical characterization of the vestibular nerves in women with vulvar vestibulitis syndrome. *Gynecologic and Obstetric Investigation*, *48,* 270–275. [Graziottin]

Bohm-Starke, N., Hilliges, M., Blomgren, B., Falconer, C., & Rylander, E. (2001). Increased blood flow and erythema in posterior vestibular mucosa in vulvar vestibulitis. *American Journal of Obstetricics and Gynecology*, *98,* 1067–1074. [Graziottin]

Bohm-Starke, N., Hilliges, M., Brodda-Jansen, G., Rylander, E., & Torebjork, E. (2001). Psychophysical evidence of nociceptor sensitization in vulvar vestibulitis syndrome. *Pain*, *94,* 177–183. [Graziottin]

Bonica, J. J. (1990). Definitions and taxonomy of pain. In J. Bonica (Ed.), *The management of pain* (pp. 18–27). Philadelphia: Lea & Febiger. [Graziottin]

Bornstein, J., Zarfati, D., Goldik, Z., & Abramovici, H. (1999). Vulvar vestibulitis: Physical or psychosexual problem? *Obstetrics & Gynecology*, *93,* 876–880. [Dunne & Najman]

Boston Women's Healthbook Collective. (1998). *Our bodies, ourselves for the new century*. New York: Simon & Schuster. [Tiefer]

Brett, E. A. (1996). The classification of posttraumatic stress disorder. In B. A. van der Kolk, A. C. McFarlane, et al. (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 117–128). New York: Guilford Press. [Carpenter & Anderson]

Bulik, C. M., Prescott, C. A., & Kendler, K. S. (2001). Features of childhood sexual abuse and the development of psychiatric and substance use disorders. *British Journal of Psychiatry*, *179,* 444–449. [Dunne & Najman]

Carnes, P. (1991). *Don't call it love*. New York: Bantam. [Kleinplatz]

Chiozza, M. L., & Graziottin, A. (in press). Urge incontinence and FSD: A life span perspective *Urodinamica*. [Graziottin]

Cleary, P., Burns, B., & Nycz, G. (1990). The identification of psychiatric illness by primary care physicians: The effect of patient gender. *Journal of General and Internal Medicine*, *5,* 355–360. [Townsend]

Danielsson, I., Sjöberg, I., Stenlund, H., & Wikman, M. (2003). Prevalence and incidence of prolonged and severe dyspareunia in women: Results from a population study. *Scandinavian Journal of Public Health*, *31,* 113–118. [Masheb & Richman]

Dennerstein, G. J., & Scurry J. (1999). [Letter to the Editor]. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *39,* 397. [Dennerstein]

Dodson, M. G., & Friedrich, B. (1978). Psychosomatic vulvovaginitis. *Obstetrics and Gynecology*, *51*(Supp.), 23–35. [Kaler]

Donovan, J. C. (1951). Menopausal syndrome: A study of case histories. *American Journal of Obstetrics and Gynecology*, *62,* 1281. [Townsend]

Dunne, M. P., Purdie, D. M., Cook, M. D., Boyle, F. M., & Najman, J. M. (2003). Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia. *Child Abuse and Neglect*, *27,* 141–152. [Dunne & Najman]

Eagle, M. (1993). Enactments, transference, and symptomatic cure: A case history. *Psychoanalytic Dialogues*, *3,* 93–110. [Wakefield]

Edgardh, K., & Abdelnoor, M. (2003). Longstanding vulval problems and early dyspareunia among STD-clinic visitors in Oslo: Results from a cross-sectional study. *International Journal of STD & AIDS*, *14,* 796–799. [Dunne & Najman]

Fergusson, D. M., & Mullen, P. E. (1999). *Childhood sexual abuse: An evidence-based perspective*. Thousand Oaks, CA: Sage. [Dunne & Najman]

Finestone, H. M., Stenn, P., Davies, F., Stalker, C., Fry, R., & Koumanis, J. (2000). Chronic pain and health care utilization in women with a history of childhood sexual abuse. *Child Abuse & Neglect*, *24,* 547–556. [Dunne & Najman]

First, M. B., Pincus, H. A., Levine, J. B., Williams, J. B. W., Ustun, B., & Peele, R. (2004). Clinical utility as a criterion for revising psychiatric diagnosis. *American Journal of Psychiatry*, *161,* 946–954. [First]

Fogerhaugh, S. Y. (1974). Pain expression and control on a burn unit. *Nurse Outlook*, *22,* 45–50. [Markos]

Ford, C. V. (1986). The somatizing disorders. *Psychosomatics*, *27,* 327–337. [Black]

Franklin, C. L., & Zimmerman, M. (2001). Posttraumatic stress disorder and major depressive disorder: Investigating the role of overlapping symptoms in diagnostic comorbidity. *Journal of Nervous and Mental Disease*, *189,* 548–551. [Carpenter & Anderson]

Friedrich, E. G. (1987). Vulvar vestibulitis syndrome. *Journal of Reproductive Medicine*, *32,* 110–114. [Graziottin]

Gates, E. A., & Galask, R. P. (2001). Psychological and sexual functioning in women with vulvar vestibulitis. *Journal of Psychosomatic Obstetrics and Gynaecology*, *22,* 221–228. [Payne]

GMC. (2004). The duties of a doctor registered with the General Medical Council. In *Good medical practice* (p. 3). London: General Medical Council. [Markos]

Golding, J. M. (1994). Sexual assault history and physical health in randomly selected Los Angeles women. *Health Psychology*, *13,* 130–138. [Dunne & Najman]

Granot, M., Friedman, M., Yarnitsky, D., & Zimmer, E. Z. (2002). Enhancement of the perception of systemic pain in women with vulvar vestibulitis. *British Journal of Obstetrics and Gynecology*, *109,* 863–866. [Meana]

Graziottin, A. (2001). Clinical approach to dyspareunia. *Journal of Sex & Marital Therapy*, *27,* 489–501. [Carpenter & Anderson, Graziottin]

Graziottin, A. (2003a). Etiology and diagnosis of coital pain. *Journal of Endocrinological Investigation*, *26,* 115–121. [Graziottin]

Graziottin, A. (2003b). Dyspareunia: clinical approach in the perimenopause. In J. Studd (Ed.), *The management of the menopause* (Third ed., pp. 229–241). London: Parthenon Publishing. [Graziottin]

Graziottin, A. (2003c). Sexuality in postmenopause and senium. In C. Lauritzen & J. Studd (Eds.), *Current management of the menopause* (pp. 185–203). London: Martin Duniz. [Graziottin]

Graziottin, A., Bottanelli, M., & Bertolasi, L. (in press). Vaginismus: A clinical and pathophysiological study. *Urodinamica.* [Graziottin]

Graziottin, A., & Brotto L. A. (2004). Vulvar vestibulitis syndrome: A clinical approach. *Journal of Sex and Marital Therapy*, *30,* 125–139. [Graziottin]

Graziottin, A., Castoldi, E., Montorsi, F., Salonia, A., & Maga, T. (2001). Vulvodynia: The challenge of "unexplained" genital pain. *Journal of Sex and Marital Therapy*, *27,* 503–512. [Kaler]

Graziottin, A., Nicolosi, A. E., & Caliari, I. (2001a, October). *Vulvar vestibulitis and dyspareunia: Addressing the biological etiologic complexity*. Poster presented at the International Meeting of the Female Sexual Function Forum, Boston, MA. [Graziottin]

Graziottin, A., Nicolosi, A. E., & Caliari, I. (2001b, October). *Vulvar vestibulitis and dyspareunia: Addressing the psychosexual etiologic complexity*. Poster presented at the International Meeting of the Female Sexual Function Forum, Boston, MA. [Graziottin]

Graziottin, A., Nicolosi, A. E., & Caliari, I. (2001c, October). *Vulvar vestibulitis and dyspareunia: The "pain map" and the medical diagnosis*. Poster presented at the International Meeting of the Female Sexual Function Forum, Boston, MA. [Graziottin]

Graziottin, A., & Vincenti, E. (2002, October). *Anthalgic treatment of intractable pain due to vulvar vestibulitis syndrome: preliminary results with oral gabapentin and anesthetic block of ganglion impar.* Poster presented at the International Meeting of the International Society for the Study of Women's Sexual Health (ISSWSH), Vancouver, BC. [Graziottin]

Green, C. R., Flowe-Valencia, H., Rosenblum, L. & Tait, A. R. (1999). Do physical and sexual abuse differentially affect chronic pain states in women? *Journal of Pain and Symptom Management*, *18,* 420–426. [Dunne & Najman]

Harlow, B. L., & Stewart, E. G. (2003). A population-based assessment of chronic unexplained vulvar pain: Have we underestimated the prevalence of vulvodynia? *Journal of the American Medical Women's Association*, *58,* 82–88. [Masheb & Richman]

Heiman, J. R. (1995). Genital pain in the context of chronic pain and an incest history. In R. C. Rosen & S. R. Leiblum (Eds.), *Case studies in sex therapy* (pp. 209–231). New York: Guilford Press. [Carpenter & Anderson]

Heiman, J. R. (2002). Psychologic treatments for female sexual dysfunction: Are they effective and do we need them? *Archives of Sexual Behavior*, *31,* 445–450. [Meana]

Heiman J. R., & Meston C. M. (1997). Empirically validated treatment for sexual dysfunction. *Annual Review of Sex Research*, *8,* 148–194. [Meana]

Hulme, P. A. (2000). Symptomatology and health care utilization of women primary care patients who experienced childhood sexual abuse. *Child Abuse & Neglect*, *24,* 1471–1484. [Dunne & Najman]

Irvine, J. M. (1990). *Disorders of desire: Sex and gender in modern American sexology.* Philadelphia: Temple University Press. [Tiefer]

Jantos, M., & White, G. (1997). The vestibulitis syndrome: Medical and psychosexual assessment of a cohort of patients. *Journal of Reproductive Medicine*, *42,* 145–152. [Payne]

Kafka, M. P. (2001). The paraphilia-related disorders: A proposal for a unified classification of nonparaphilic hypersexuality disorders. *Sexual Addiction & Compulsivity*, *8,* 227–239. [Kleinplatz]

Kaler, A. (2003). *Biomedical metaphors of vulvar pain*. Manuscript submitted for publication. [Kaler]

Kaplan, H. S. (1974). *The new sex therapy*. New York: Brunner/Mazel. [Moser]

Kaplan, H. S. (1977). Hypoactive sexual desire. *Journal of Sex & Marital Therapy*, *3,* 3–9. [Tiefer]

Kaschak, E., & Tiefer, L. (Eds.). (2001). *A new view of women's sexual problems*. Thousand Oaks, CA: Sage Publications. [Tiefer]

Kendell, R., & Jablensky, A. (2003). Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry*, *160,* 4–12. [First, Levine]

Kim, E. Y., & Miklowitz, D. J. (2002). Childhood mania, attention deficit hyperactivity disorder, and conduct disorder: A critical review of diagnostic dilemmas. *Bipolar Disorders*, *4,* 215–225. [Carpenter & Anderson]

Kleinman, A. (1988). *The illness narratives*. New York: Basic Books. [Townsend]

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, *88,* 251–258. [Townsend]

Kleinplatz, P. (2001) A critique of the goals of sex therapy, or the hazards of safer sex. In P. Kleinplatz Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 109–131). Philadelphia: Brunner-Routledge. [Tiefer]

Kleinplatz, P. J. (2005). Adding insult to injury: The classification of dyspareunia as a sexual dysfunction in the DSM. *Archives of Sexual Behavior*, *34,* 36–38. [Moser]

Konstantareas, M. M., & Hewitt, T. (2001). Autistic disorder and schizophrenia: Diagnostic overlaps. *Journal of Autism & Developmental Disorders*, *31,* 19–28. [Carpenter & Anderson]

Lampe, A., Doering, S., Rumpold, G., Solder, E., Krismer, M., Kantner-Rumplmair, W., et al. (2003). Chronic pain syndromes and their relation to childhood sexual abuse and stressful life events. *Journal of Psychosomatic Research*, *54,* 361–367. [Dunne & Najman]

Laumann, E. O., Paik, A., & Rosen, R. C. (1999). Sexual dysfunction in the United States. *Journal of the American Medical Association*, *281,* 537–544. [Dunne & Najman, Graziottin]

Laumann, E. O., Paik, A., & Rosen, R. C. (2001). Sexual dysfunction in the United States: Prevalence and predictors. In E. O. Laumann & R. T. Michael (Eds.), *Sex, love, and health in America: Private choices and public policies* (pp. 352–376). Chicago: University of Chicago Press. [Carpenter & Anderson]

Levine, S. B. (2003). The nature of sexual desire: A clinician's perspective. *Archives of Sexual Behavior*, *32,* 279–285. [Levine]

Lief, H. (1977). What's new in sex research? Inhibited sexual desire. *Medical Aspects of Human Sexuality*, *2,* 94–95. [Tiefer]

Linton, S. J. (1997). A population-based study of the relationship between sexual abuse and back pain: Establishing a link. *Pain*, *73,* 47–53. [Dunne & Najman]

Lipowski, Z. J. (1987). Somatization: Medicine's unsolved problem. *Psychosomatics*, *28,* 294, 297. [Black]

Marin, G., & Dennerstein, G. (2002). Vulvar vestibulitis: A real syndrome? [Letter to the Editor]. *Journal of Reproductive Medicine*, *47,* 775. [Dennerstein]

Marin, M. G., King, R., Dennerstein, G. J., & Sfameni, S. (1998). Dyspareunia and vulvar disease. *Journal of Reproductive Medicine*, *43,* 952–958. [Dennerstein]

Masheb, R. M., Brondolo, E., & Kerns, R. D. (2002). A multidimensional, case-control study of women with self-identified chronic vulvar pain. *Pain Medicine*, *3,* 253–259. [Masheb & Richman]

Masheb, R. M., Nash, J. M., Brondolo, E., & Kerns, R. D. (2000). Vulvodynia: An introduction and critical review of a chronic pain condition. *Pain*, *86,* 3–10. [Masheb & Richman]

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Boston: Little, Brown and Co. [Tiefer]

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Boston: Little, Brown. [Moser]

Maurice, W. L. (1999). *Sexual medicine in primary care*. St. Louis: Mosby. [Kleinplatz]

McCaffory, M., & Paseroc, C. L. (1997). Pain ratings: The fifth vital sign. *American Journal of Nursing*, *97,* 15–16. [Markos]

McCormick, N. (1994). *Sexual salvation: Affirming women's sexual rights and pleasures*. Westport, CT: Praeger. [Tiefer]

Meana, M., & Binik, Y. M. (1994). Painful coitus: A review of female dyspareunia. *Journal of Nervous and Mental Disease*, *182,* 264–272. [Meana]

Meana, M., Binik, Y. M., Khalifé, S., & Cohen, D. (1997a). Dyspareunia: Sexual dysfunction or pain syndrome? *Journal of Nervous and Mental Disease*, *185,* 561–569. [Carpenter & Anderson, Meana]

Meana, M., Binik, Y. M., Khalifé, S., Cohen, D. R. (1997b). Biopsychosocial profile of women with dyspareunia. *Obstetrics & Gynecology*, *98,* 45–51. [Graziottin, Meana, Payne]

Meana, M., Binik, Y. M., Khalifé, S., & Cohen, D. (1999a). Psychosocial correlates of pain attribution in women with dyspareunia. *Psychosomatics*, *40,* 497–503. [Kaler, Meana, Wakefield]

Meana, M., Binik, Y. M., Khalifé, S., & Cohen, D. (1999b). Dyspareunia: Sexual dysfunction or pain syndrome? *Journal of Nervous and Mental Disease*, *185,* 561–569. [Wakefield]

Mersky, H., & Bagduk, N. (1994). *Classification of chronic pain* (2nd ed.) Seattle, WA: IASP. [Markos]

Moser, C. (2001). Paraphilia: Another confused sexological concept. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 91–108). Philadelphia: Brunner-Routledge. [Kleinplatz, Moser]

Moser, C. (2002). Are any of the paraphilias in the *DSM* mental disorders? *Archives of Sexual Behavior*, *31,* 490–491. [Moser]

Moser, C. (2005). Dyspareunia: Another argument for removal. *Archives of Sexual Behavior*, *34,* 44–46. [Kleinplatz]

Moser, C., & Kleinplatz, P. J. (2002). Transvestic fetishism: Psychopathology or iatrogenic artifact? *New Jersey Psychologist*, *52*(2), 16–17. [Kleinplatz, Moser]

Moser, C., & Kleinplatz, P. J. (in press). DSM-IV-TR and the paraphilias: An argument for removal. *Journal of Psychology and Human Sexuality*. [Kleinplatz, Moser]

Najman, J. M., Dunne, M. P., Boyle, F. M., Cook, M. D., & Purdie, D. M. (2003). Sexual dysfunction in the Australian population. *Australian Family Physician*, *32,* 951-954. [Dunne & Najman]

Nathan, S. (2003). How to know when a woman is sexually dysfunctional. In S. B. Levine, C. B. Risen, & S. E. Althof (Eds.), *Handbook of clinical sexuality for mental health professionals* (pp. XXX–XXX). New York: Brunner/Routledge. [Levine]

Nickel, R., Egle, U. T., & Hardt, J. (2002). Are childhood adversities relevant in patients with chronic back pain? *European Journal of Pain*, *6,* 221–228. [Dunne & Najman]

Nunns, D., & Mandal, D. (1997). Psychological and psychosexual aspects of vulvar vestibulitis. *Genitourinary Medicine*, *73,* 541–544. [Payne]

O'Connor, V., & Kovacs, G. (2003). *Obstetrics, gynaecology and women's health*. Cambridge, England: Cambridge University Press. [Dennerstein]

Pagano, R. (1999). Vulvar vestibulitis syndrome: An often-unrecognised cause of dyspareunia. *Australian & New Zealand Journal of Obstetrics & Gynaecology*, *39,* 79–83. [Black]

Pappagalo, M., Szabo, Z., Esposito, G., Lokesh, A., & Velez, L. (2002). Imaging neurogenic inflammation in patients with migraine headaches. *Neurology*, *52,* 274–275. [Basson]

Payne, K. A., Binik, Y. M., Amsel, R., & Khalifé, S. (2005; in press). *When sex hurts, anxiety and fear orient attention towards pain*. *European Journal of Pain*. [Payne]

Phillips, K. A., Price, L. H., Greenberg, S. A., & Rasmussen, S. A. (2003). Should the DSM diagnostic groupings be changed? In K. A. Phillips, M. B. First, & H. A. Pincus (Eds.), *Advancing DSM: Dilemmas in psychiatric diagnosis* (pp. 57–84). Washington, DC: American Psychiatric Publishing, Inc. [First]

Pilowsky, I. (1978). A general classification of abnormal illness behaviours. *British Journal of Medical Psychology*, *51,* 131–137. [Black]

Pope, H. G., & Lipinski, J. F. (1978). Diagnosis in schizophrenia and manic-depressive illness: A reassessment of the specificity of "schizophrenic: symptoms in the light of current research. *Archives of General Psychiatry*, *35,* 811-828. [First]

Pukall, C. F., Binik, Y. M., Khalifé, S., Amsel, R., & Abbott, F. V. (2002). Vestibular tactile and pain thresholds in women with vulvar vestibulitis syndrome. *Pain*, *96,* 163–175. [Carpenter & Anderson, Graziottin, Meana, Wakefield]

Pukall, C. F., Payne, K. A., Binik, Y. M., & Khalifé, S. (2003). Pain measurement in vulvodynia. *Journal of Sex and Marital Therapy*, *29*(Suppl.), 111–120. [Payne]

Pukall, C. F., Strigo, I. A., Binik, Y. M., Khalifé, S., & Bushnell, C. (2003). *Vulvar vestibulitis syndrome is a pain disorder: Evidence from functional magnetic resonance imaging*. Manuscript submitted for publication. [Graziottin, Meana]

Purdie, D. M., Dunne, M. P., Boyle, F. M., Cook, M. D., & Najman, J. M. (2002). Health and demographic characteristics of volunteers in an Australian national sexuality survey. *Journal of Epidemiology & Community Health*, *56,* 748–753. [Dunne & Najman]

Raphael, K. G., Widom, C. S., & Lange, G. (2001). Childhood victimization and pain in adulthood: A prospective investigation. *Pain*, *92,* 283–293. [Dunne & Najman]

Redman, S., Webb, G., Hennrikus, D., Gordon, J., & Sanson-Fisher, R. (1991). The effects of gender on diagnosis of psychological disturbance. *Journal of Behavioral Medicine*, *14,* 441–451. [Townsend]

Reilly, J., Baker, G. A., Rhodes, J., & Salmon, P. (1999). The association of sexual and physical abuse with somatization: Characteristics of patients presenting with irritable bowel syndrome and non-epileptic attack disorder. *Psychological Medicine*, *29,* 399–406. [Dunne & Najman]

Reissing, E. D., Binik, Y. M., Khalifé, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema, and relationship adjustment. *Journal of Sex and Martial Therapy*, *29,* 47–59. [Payne]

Rennard, S. I. (2004). Looking at the patient–Approaching the problem of COPD. *New England Journal of Medicine*, *350,* 965–966. [Levine]

Romans, S., Belaise, C., Martin, J., Morris, E., & Raffi, A. (2002). Childhood abuse and later medical disorders in women: An epidemiological study. *Psychotherapy & Psychosomatics*, *3,* 141–151. [Dunne & Najman]

Rosser, B. R. S., Short, B. J., Thurmes, P. J., & Coleman, E. (1998). Anodyspareunia, the unacknowledged sexual dysfunction: A validation study of painful receptive anal intercourse and its psychosexual concomitants in homosexual men. *Journal of Sex & Marital Therapy*, *24,* 281–292. [Wakefield]

Sackett, S., & Galask, R. (2002). Reply to Marin and Dennerstein [Letter to the Editor]. *Journal of Reproductive Medicine*, *47,* 775–776. [Dennerstein]

Salonia, A., Zanni, G., Nappi, R. E., Briganti, A,. Deho, F., Fabbri, F., et al. (2004). Sexual dysfunction is common in women with lower urinary tract symptoms and urinary incontinence: results of a cross-sectional study. *European Urology*, *45,* 642–648. [Graziottin]

Schiavi, R. C. (1996). Sexual pain disorders. In T. A. Widiger, A. J. Frances, H. A. Pincus, R. Ross, M. B. First, & W. Davis (Eds.), *DSM-IV sourcebook* (Vol. 2, pp. 1129–1131). Washington, DC: American Psychiatric Association. [First]

Schloredt, K. A., & Heiman, J. R. (2003). Perceptions of sexuality as related to sexual functioning and sexual risk in women with different types of childhood abuse histories. *Journal of Traumatic Stress*, *16,* 275–284. [Dunne & Najman]

Schover, L. R. (1995). It's not all in your head: Integrating sex therapy and surgery in treating a case of chronic vulvar pain. In R. C. Rosen & S. R. Leiblum (Eds.), *Case studies in sex therapy* (pp. 295–310). New York: Guilford Press. [Carpenter & Anderson]

Schover, L. R., & Leiblum, S. R. (1994). Commentary: The stagnation of sex therapy. *Journal of Psychology and Human Sexuality*, *6*(3), 5–30. [Meana]

Segraves, R. T. (2001). Editor's comments. *Journal of Sex & Marital Therapy*, *27,* 81. [Kleinplatz]

Singh, B., Nunn, K., & Yates, J. (1981). Abnormal treatment behaviour. *British Journal of Medical Psychology*, *54,* 67–73. [Black]

Spitzer, R. L., & Wakefield, J. C. (1999). DSM-IV diagnostic criterion for clinical significance: Does it help solve the false positives problem? *American Journal of Psychiatry*, *156,* 1856–1864. [Wakefield]

Strassberg, D. S. (1994). A physiologically based model of early ejaculation: A solution or a problem? *Journal of Sex Education and Therapy*, *20,* 215–217. [Strassberg]

Strassman, A. M., Raymond, S. A., & Burstein, R. (1996). Sensitization of meningeal sensory neurons and the origin of headaches. *Nature*, *385,* 560–564. [Basson]

Tarr, G., Selo-Ojeme, D. O., & Onwude, J. L. (2003). Co-existence of vulvar vestibulitis and interstitial cystitis. *Acta Obstetricia et Gynecologica Scandinavica*, *82,* 969–974. [Graziottin]

Taylor, M. L., Trotter, D. R., & Csuka, M. E. (1995). The prevalence of sexual abuse in women with fibromyalgia. *Arthritis & Rheumatism*, *38,* 229–234. [Dunne & Najman]

Tiefer, L. (1988). A feminist critique of the sexual dysfunction nomenclature. *Women and Therapy*, *7,* 5–21. [Tiefer]

Tiefer, L. (1991). Historical, scientific, clinical and feminist criticisms of "the human sexual response cycle" model. *Annual Review of Sex Research*, *2,* 1–23. [Tiefer]

Tiefer, L. (1992). Critique of the DSM-IIIR nosology of sexual dysfunctions. *Psychiatric Medicine*, *10,* 227–245. [Tiefer]

Tiefer, L. (1994). Might premature ejaculation be organic? The perfect penis takes a step forward. *Journal of Sex Education and Therapy*, *20,* 7–8. [Strassberg]

Tiefer, L. (1996). The medicalization of sexuality: Conceptual, normative, and professional issues. *Annual Review of Sex Research*, *7,* 252–282. [Tiefer]

Tiefer, L. (2001a). Arriving at a "new view" of women's sexual problems: Background, theory, and activism. In E. Kaschak & L. Tiefer (Eds.), *A new view of women's sexual problems* (pp. 63–98). Binghamton, NY: Haworth. [Tiefer]

Tiefer, L. (2001b). Arriving at a "new view" of women's sexual problems: Background, theory and activism. *Women and Therapy*, *24,* 63–98. [Meana]

Tiefer, L. (2004). *Sex is not a natural act, and other essays*. (Second ed.). Boulder, CO: Westview Press. [Tiefer]

Townsend, J. M. (1978). *Cultural conceptions and mental illness*. Chicago: University of Chicago Press. [Townsend]

Townsend, J. M. (1980). Menopausal syndrome: Illness or social role–A transcultural analysis. *Culture, Medicine, and Psychiatry*, *4,* 101–120. [Townsend]

Townsend, J. M. (1982). Psychiatric versus social factors: An attempt at integration. *Human Relations*, *35,* 785–804. [Townsend]

Townsend, J. M. (1995). Racial, ethnic, and mental illness stereotypes: Cognitive process and behavioral effects." In C. V. Willie (Ed.), *Mental health, racism, and sexism* (pp. 119–147). Pittsburgh, PA: University of Pittsburgh Press. [Townsend]

Townsend, J. M. (1998). *What women want–What men want*. New York: Oxford University Press. [Townsend]

Tyrer, S. P. (1986). Learned pain behaviour. *British Medical Journal*, *292,* 1. [Black]

Utian, W. H. (1979). Estrogen replacement in the menopause. *Obstetrics and Gynecology Annual*, *8,* 369–391. [Townsend]

van Lankveld, J. J., Weijenborg, P. T., & Ter Kuile, M. M. (1996). Psychologic profiles of and sexual function in women with vulvar vestibulitis and their partners. *Obstetrics and Gynecology*, *88,* 65–70. [Payne]

Vincenti, E., & Graziottin, A. (in press). Neuropathic pain in vulvar vestibulitis: Diagnosis and treatment. *Urodinamica*. [Graziottin]

Wakefield, J. C. (1992). The concept of mental disorder: On the boundary between biological facts and social values. *American Psychologist*, *47,* 373–388. [Wakefield]

Wakefield, J. C. (1999). Evolutionary versus prototype analyses of the concept of disorder. *Journal of Abnormal Psychology*, *108,* 374–399. [Wakefield]

Walker, E. A., Gelfand, A., Katon, W. J., Koss, M. P., Von Korff, M., Bernstein, D., et al. (1999). Adult health status of women with histories of childhood abuse and neglect. *American Journal of Medicine*, *107,* 332–339. [Dunne & Najman]

Widiger, T. A., & Clark, L.A. (2000). Toward DSM-V and the classification of psychopathology. *Psychological Bulletin*, *126,* 946–963. [Carpenter & Anderson]

Wouda, J. C., Hartman, P. M., Bakker, R. M., Bakker, J. O., van de Wiel, H. B. M., & Weijmar Schulz, W. C. M. (1998). Vaginal plethysmography in women with dyspareunia. *Journal of Sex Research*, *35,* 143–147. [Carpenter & Anderson, Payne]

Zolnoun, D. A, Hartmann, K. E., & Steege, J. F. (2003). Overnight 5% lidocaine ointment for treatment of vulvar vestibulitis. *Obstetrics and Gynecology*, *102,* 84–87. [Basson]