psychiatry international

MDPI

Review

Unspecified Sexual Dysfunction in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*—Diagnostic Classification, Systemic Assessment, and Clinical Intervention

Jimmie Manning

Communication Studies Department, University of Nevada, Mail Stop 0229, 1664 North Virginia Street, Reno, NV 89523, USA; jimmiem@unr.edu

Abstract

Unspecified Sexual Dysfunction is a residual diagnostic category within the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) used when symptoms characteristic of a sexual dysfunction cause clinically significant distress but do not meet criteria for a specific sexual dysfunction and the clinician does not specify the reason, including situations in which insufficient information is available for a more specific diagnosis. This narrative literature review examines diagnostic classification and clinical assessment in such presentations and considers how systemic perspectives can complement psychiatric assessment and intervention. A literature search using Google Scholar and citation-network mapping identified 34 peer-reviewed sources addressing sexual dysfunction classification, assessment, biopsychosocial and relational aspects of sexual distress, and treatment. The literature supports a distinction between diagnostic classification and comprehensive clinical formulation. Biological, psychological, relational, sociocultural, and developmental aspects do not constitute diagnostic criteria for Unspecified Sexual Dysfunction but may provide clinically relevant information for understanding sexual distress and selecting appropriate interventions. Systemic and relational assessment may therefore complement DSM-5-TR diagnosis by identifying interpersonal and contextual aspects relevant to treatment planning without redefining the diagnosis itself. Integrating diagnostic evaluation with broader clinical formulation may support individualized treatment and interdisciplinary collaboration across psychiatry, sexual medicine, psychosexual therapy, and relational or systemic care.

Keywords: unspecified sexual dysfunction; sexual distress; systemic assessment; clinical formulation; biopsychosocial model; differential diagnosis; DSM-5-TR; psychiatric nosology; couple therapy; interpersonal communication

Check for updates

Received: 11 March 2026
Revised: 26 August 2026
Accepted: 27 August 2026
Published: 1 September 2026

Copyright: © 2026 by the author. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license.

1. Introduction

Unspecified Sexual Dysfunction is a residual diagnostic category within the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) used for presentations in which symptoms characteristic of a sexual dysfunction cause clinically significant distress but do not meet the full criteria for a specific disorder within the sexual dysfunctions diagnostic class. The category is used when the clinician does not specify why criteria for a specific sexual dysfunction are not met and includes presentations for which insufficient information is available to make a more specific diagnosis [1]. Although

residual diagnostic categories are common across psychiatric classification systems, the unspecified designation occupies an important yet underexamined position within sexual dysfunction nosology. Its use may reflect diagnostic nonspecificity when a presentation does not meet criteria for a specific sexual dysfunction or diagnostic uncertainty when insufficient information is available for more precise classification. These diagnostic circumstances should be distinguished from the broader biological, psychological, relational, and sociocultural aspects that may contribute to sexual distress but do not themselves constitute criteria for Unspecified Sexual Dysfunction.

Sexual dysfunctions more broadly involve clinically significant disturbances in an individual's ability to respond sexually or experience sexual pleasure, including difficulties involving sexual interest or desire, arousal, orgasm, or pain associated with sexual activity [1]. Specific DSM-5-TR sexual dysfunction diagnoses include disorder-specific symptom, duration, frequency, distress, and exclusion criteria, and these requirements should not be generalized across the diagnostic class. Diagnostic assessment also requires consideration of whether a presentation is better explained by factors specified for the relevant disorder, including another mental disorder, severe relationship distress or other significant stressors, substance or medication effects, or medical conditions [1]. These diagnostic considerations underscore the importance of careful differential assessment while remaining distinct from broader systemic case formulation.

Historically, diagnostic frameworks have organized sexual dysfunction around stages of the sexual response cycle, including desire, arousal, orgasm, and pain-related disturbances [2]. Empirical and clinical research demonstrates that sexual functioning is also shaped by interacting biological, psychological, relational, and sociocultural influences [3,4]. Psychological processes such as anxiety, attentional disruption, and maladaptive sexual beliefs may contribute to sexual difficulties, while interpersonal dynamics—including partner expectations, communication patterns, and relational stress—can influence sexual experiences and distress. Such findings do not establish relational or contextual factors as diagnostic criteria; rather, they demonstrate the broader range of considerations that may inform clinical formulation alongside diagnostic assessment.

Efforts to refine the classification and nomenclature of female sexual dysfunction have also emerged within sexual medicine. Parish et al. [5] argue that existing DSM definitions do not capture the full range of sexual problems encountered in clinical settings and call for more precise terminology to support research and clinical management.

Within this broader diagnostic landscape, DSM-5-TR distinguishes Other Specified Sexual Dysfunction from Unspecified Sexual Dysfunction. Other Specified Sexual Dysfunction is used when the clinician identifies and communicates the specific reason that a presentation causing clinically significant distress does not meet criteria for a particular sexual dysfunction, whereas Unspecified Sexual Dysfunction is used when the clinician chooses not to specify that reason or when insufficient information is available to make a more specific diagnosis [1]. The unspecified category therefore provides a mechanism within DSM-5-TR for accommodating presentations that cannot be assigned a more specific sexual dysfunction diagnosis. At the same time, diagnostic classification alone does not provide a comprehensive formulation of the biological, psychological, relational, developmental, or sociocultural aspects that may contribute to an individual's sexual distress.

Diagnostic classification and systemic case formulation consequently serve related but distinct clinical purposes. DSM-5-TR classification identifies whether a presentation meets criteria for a recognized diagnostic category but does not seek to provide a comprehensive etiological account of the patient's sexual distress. Systemic assessment can complement this diagnostic process by examining biological, psychological, relational, developmental, and sociocultural aspects relevant to case formulation and treatment planning. Cases clas-

sified as Unspecified Sexual Dysfunction therefore provide a useful context for considering how diagnostic classification can be integrated with broader systemic assessment without treating relational or contextual aspects as diagnostic criteria. Such an approach preserves the distinction between DSM-5-TR diagnosis and systemic interpretation while supporting comprehensive assessment and interdisciplinary intervention.

2. Purpose of the Review

This narrative review examines diagnostic classification and clinical assessment in cases categorized as Unspecified Sexual Dysfunction and explores how systemic perspectives can complement psychiatric assessment and inform intervention. DSM-5-TR criteria for specific sexual dysfunctions require consideration of whether symptoms are better explained by other mental disorders, severe relationship distress or other significant stressors, substance or medication effects, or medical conditions, as applicable to the particular diagnosis [1]. Available evidence also indicates that sexual functioning can be shaped by interacting biological, psychological, interpersonal, and sociocultural processes [3,4]. Consideration of these broader aspects can contribute to case formulation and treatment planning while remaining conceptually distinct from DSM-5-TR diagnostic criteria.

To synthesize this body of literature, the present review examines research across psychiatry, sexual medicine, trauma scholarship, and relationship science. The analysis is abductively organized around three thematic domains: (1) classification and nosological evolution, (2) differential diagnosis and diagnostic considerations, and (3) biopsychosocial, relational, and systemic aspects of sexual distress. By integrating these domains, the review evaluates how systemic assessment can support clinical decision-making when sexual symptoms do not map clearly onto specific diagnostic categories. The review therefore considers how systemic and relational perspectives can complement psychiatric assessment and contribute to broader clinical formulation without being construed as diagnostic criteria for Unspecified Sexual Dysfunction.

In line with this purpose, the following central question guides the review: What does the available literature suggest about diagnostic classification, systemic assessment, and clinical intervention in presentations of sexual distress that do not meet criteria for a specific DSM-5-TR sexual dysfunction diagnosis?

3. Narrative Literature Review Methods

3.1. Identification of Literature

This study employs a narrative literature review approach [6,7] to integrate scholarship across clinical psychiatry, sexual medicine, relationship science, and systemic psychotherapy. A literature search was conducted to identify peer-reviewed scholarship relevant to sexual dysfunction classification, Unspecified Sexual Dysfunction, clinical assessment, and systemic perspectives on sexual distress.

Initial searches were conducted in Google Scholar using combinations of the terms *sexual dysfunction*, *sexual distress*, *unspecified sexual dysfunction*, *DSM-5-TR*, *systemic assessment*, *relational processes*, and *couple therapy*. Searches were conducted between January and February 2026 and focused primarily on literature published during the preceding 25 years, while allowing inclusion of earlier foundational sources when identified as conceptually important through citation mapping.

The author screened search results for relevance to sexual dysfunction diagnosis, psychiatric assessment, and systemic or relational approaches to assessment and treatment. Duplicate records and publications that did not substantively address the review question were excluded. Remaining publications were evaluated for conceptual relevance, after

which backward and forward citation mapping was used to identify additional potentially relevant literature.

Publications identified as particularly relevant were entered into Research Rabbit, an AI-assisted citation-network mapping tool, to identify connected foundational and recent scholarship. Research Rabbit was used solely for literature discovery and did not make inclusion, exclusion, analysis, or interpretive decisions. All records identified through citation mapping were independently reviewed by the author for relevance and eligibility, and bibliographic information was verified against the original publications before inclusion. The author made all final decisions regarding source selection, synthesis, and interpretation.

Sources were eligible for inclusion if they were peer-reviewed and contributed substantively to the review question by (1) addressing sexual dysfunction diagnosis or classification, (2) examining assessment or intervention, or (3) informing psychiatric, biopsychosocial, systemic, or relational case formulation. Opinion pieces lacking substantive clinical or conceptual analysis, conference abstracts, duplicate records, and publications that did not substantively address the review question were excluded.

The final corpus comprised 34 sources, including empirical studies, systematic reviews, consensus statements, clinical analyses, and theoretical or integrative frameworks. Because the purpose was narrative synthesis rather than exhaustive evidence identification or quantitative aggregation, sources were selected for their relevance to the review question and contribution to the interdisciplinary conceptual synthesis.

3.2. Narrative Literature Review Approach

Because research on sexual dysfunction spans multiple disciplines and methodological traditions, a narrative synthesis approach was used to integrate findings across heterogeneous forms of scholarship [7]. Narrative reviews are particularly suited to interdisciplinary topics where the goal is to identify conceptual patterns rather than aggregate findings through formal meta-analysis or citation analysis [8].

Narrative synthesis served two primary analytic goals. First, it integrated literature addressing DSM-5-TR classification, diagnostic assessment, and treatment of sexual dysfunction, including the use of residual categories such as Unspecified Sexual Dysfunction. Second, it examined biopsychosocial, systemic, and relational literature relevant to broader case formulation and intervention. These bodies of literature were considered as complementary but conceptually distinct: relational and systemic aspects were examined as potential contributors to sexual distress and clinical formulation rather than as DSM-5-TR diagnostic criteria.

Through iterative analysis of the selected corpus, six recurring thematic domains were identified. These domains structure the review and provide a framework for examining diagnostic classification, differential assessment, biopsychosocial and relational aspects of sexual distress, and treatment approaches.

3.3. Conceptual Themes in the Literature on Unspecified Sexual Dysfunction

Across the 34 sources, six recurring domains were identified: (1) epidemiological patterns and prevalence estimates across sexual dysfunctions; (2) diagnostic classification and nosology; (3) biopsychosocial models of sexual functioning; (4) relational and interpersonal aspects of sexual distress; (5) treatment evidence and clinical intervention; and (6) diagnostic considerations associated with residual categories such as Unspecified Sexual Dysfunction.

These domains were examined with attention to the distinction between diagnostic classification and broader clinical formulation. Unspecified Sexual Dysfunction accommo-

dates presentations in which symptoms characteristic of sexual dysfunction cause clinically significant distress but do not meet criteria for a specific sexual dysfunction and the clinician does not specify the reason, including situations in which insufficient information is available for a more specific diagnosis [1]. The broader biopsychosocial, relational, developmental, and sociocultural literature reviewed here is therefore considered not as evidence for assigning the unspecified diagnosis, but as potentially relevant to comprehensive assessment, case formulation, and intervention.

4. Epidemiology of Sexual Dysfunction

Sexual dysfunctions and sexual difficulties are widely reported across diverse populations, although prevalence estimates vary considerably according to the specific condition examined, diagnostic definition, population, and measurement strategy. Reviews of community studies report meaningful prevalence across several forms of sexual dysfunction, with pooled estimates of approximately 7–10% for female orgasmic disorder and 4–5% for premature ejaculation, alongside lower but measurable rates for conditions such as male orgasmic disorder and erectile disorder [9]. Such estimates should be interpreted in relation to the definitions and assessment methods employed in individual studies rather than as prevalence estimates for sexual dysfunction as a single diagnostic category.

Large-scale international studies further demonstrate variation according to demographic, medical, and cultural contexts. The multinational MALES study of nearly 28,000 men across eight countries, for example, reported an overall prevalence of erectile dysfunction of approximately 16%, with rates varying across countries and increasing with age and medical comorbidity [10]. Broader epidemiological analyses have reported sexual difficulties or dysfunction among approximately 40–45% of adult women and 20–30% of adult men [11]. These broader estimates encompass heterogeneous sexual concerns and should not be interpreted as prevalence estimates for DSM-5-TR sexual dysfunction diagnoses specifically. Sexual difficulties may occur in different diagnostic and etiological contexts and may be associated with medical or organic conditions, medication effects, psychological factors, aging, chronic illness, cardiovascular disease, and other influences [10,11].

Sexual difficulties also remain underreported and undertreated in clinical settings. Many individuals experiencing such concerns do not seek professional help, potentially because of stigma, normalization of symptoms, or limited access to specialized care [12,13]. Even among individuals reporting clinically meaningful symptoms, only a minority receive formal diagnosis or treatment [10]. Methodological differences across epidemiological studies—including variation in diagnostic definitions, symptom thresholds, sampling strategies, and reliance on self-report—further complicate prevalence estimation [9]. Accordingly, epidemiological findings are most appropriately interpreted with attention to the particular sexual difficulty or dysfunction being assessed and the diagnostic, medical, and methodological context in which prevalence is measured.

5. Diagnostic Classification and Nosological Challenges

The available literature indicates that the classification of sexual dysfunction has continued to evolve in response to changing theoretical models of sexual response, empirical findings, and developments within psychiatry and sexual medicine [4,14,15]. Diagnostic boundaries and definitions have consequently been revised as evidence and classification systems have developed [16].

One consequential revision in the transition from DSM-IV-TR to DSM-5 was the merging of hypoactive sexual desire disorder and female sexual arousal disorder into Female Sexual Interest/Arousal Disorder (FSIAD). Proponents of this change argued that empirical

evidence demonstrated substantial overlap between desire and arousal processes in women. Critics, however, have suggested that combining these constructs may obscure clinically meaningful distinctions and complicate research design and treatment development. Fisher et al. [17], for example, describe challenges encountered in clinical trials when operationalizing diagnostic thresholds, determining responder criteria, and establishing inclusion standards for heterogeneous presentations of desire and arousal symptoms.

Classification also varies across international diagnostic frameworks and cultural contexts. Differences between DSM and ICD systems, variation in normative sexual expectations across cultures, and differences in diagnostic standards contribute to ongoing challenges in defining and measuring sexual dysfunction [18]. These differences underscore the importance of interpreting epidemiological and clinical findings in relation to the diagnostic framework, measurement strategy, and cultural context in which sexual dysfunction is assessed.

Some scholars have advocated dimensional approaches to sexual functioning that acknowledge a continuum between normative variability, transient difficulty, and clinically significant distress [4,15]. For several specific DSM-5-TR sexual dysfunction diagnoses, criteria include a minimum duration of approximately six months and requirements concerning the frequency with which symptoms occur, often approximately 75–100% of sexual encounters or activity [1]. These thresholds are disorder-specific rather than universal criteria for the sexual dysfunction diagnostic class and are intended to help distinguish persistent, clinically significant dysfunction from transient or normative variation.

Considered together, the literature demonstrates that sexual dysfunction classification has evolved as diagnostic frameworks and empirical evidence have developed. Residual categories such as Unspecified Sexual Dysfunction provide one mechanism through which DSM-5-TR accommodates presentations that cause clinically significant distress but do not meet criteria for a specific sexual dysfunction diagnosis. The presence of an unspecified classification should therefore not itself be interpreted as evidence of a limitation in categorical diagnosis. Rather, diagnostic classification can be distinguished from broader case formulation, which may incorporate biological, psychological, relational, sociocultural, and developmental aspects relevant to understanding sexual distress and planning intervention (see Table 1 for a summary of these multidimensional aspects and their potential clinical considerations).

Table 1. Multidimensional Aspects Relevant to the Assessment and Treatment of Sexual Distress.

Domain	Examples	Potential Clinical Considerations
Biological factors	Hormonal changes, medication effects, chronic illness	Medical assessment or medication review may be indicated
Psychological aspects	Anxiety, shame, trauma history, performance concerns	Psychological or trauma-informed assessment may be relevant
Relational aspects	Communication patterns, attachment insecurity, conflict cycles	Relational assessment and couple or family intervention may be considered
Sociocultural aspects	Sexual scripts, gender norms, religious beliefs	Culturally responsive assessment and psychoeducation may be relevant
Developmental context	Parenthood, aging, relationship transitions	Developmental and relational transitions may inform case formulation

These domains illustrate the range of factors that may be relevant to comprehensive assessment and case formulation without constituting diagnostic criteria for Unspecified Sexual Dysfunction. The following sections examine these aspects in greater detail, beginning with biopsychosocial models.

6. Biopsychosocial Models of Sexual Function

A biopsychosocial perspective recognizes that sexual functioning may be shaped by interacting biological, psychological, relational, and sociocultural factors. Clinical literature accordingly supports assessment across multiple domains rather than reliance on a single etiological explanation [19]. Within this framework, chronic illness, cardiovascular and metabolic conditions, neurologic disorders, endocrine changes, and medication effects have been associated with difficulties involving sexual desire, arousal, orgasm, and pain [11,20]. Epidemiological research similarly demonstrates associations between chronic health conditions and sexual dysfunction, underscoring the importance of evaluating sexual symptoms within their broader medical context [21].

Hormonal and physiological changes across the lifespan further illustrate the importance of differential assessment. Changes associated with menopause, aging, and endocrine conditions may affect physiological sexual response, genital blood flow, and vaginal lubrication. Such changes, however, do not necessarily constitute a sexual dysfunction diagnosis, particularly when symptoms do not satisfy the criteria for a specific disorder [20,22]. Medical assessment—including consideration of endocrine status, comorbid conditions, and medication use—can therefore help determine whether sexual symptoms are better explained by physiological or medical factors.

Substance use and pharmacological treatment can also affect sexual functioning. Alcohol, opioids, stimulants, and other substances may influence sexual desire, arousal, and orgasm through neurochemical, vascular, hormonal, and central nervous system processes, while commonly prescribed medications such as antidepressants and antihypertensives may produce sexual side effects [11,23]. Research involving substance use disorders has similarly documented associations with reduced libido, erectile difficulties, impaired arousal, and orgasmic difficulties [23]. These possibilities are clinically important because sexual symptoms associated with substance exposure or medication effects may be better explained by those factors than by a specific sexual dysfunction diagnosis.

Assessment should therefore consider the temporal relationship between sexual symptoms and relevant medical, pharmacological, or substance-related factors, including medication initiation or dosage changes and patterns of substance use. Such assessment can help distinguish among potential explanations for sexual symptoms and reduce the risk of premature diagnostic classification. From a biopsychosocial perspective, biological and medical assessment thus provides one component of broader clinical formulation alongside psychological, relational, and sociocultural considerations.

7. Relational Contexts of Sexual Distress

Beyond diagnostic classification, relational and systemic perspectives provide an additional framework for examining how sexual distress is experienced and maintained within intimate relationships. Research across sexual medicine, relationship science, and clinical psychology identifies associations between sexual functioning and interpersonal processes, including attachment, communication, emotional regulation, and relational meaning-making [3,24–26]. Attachment research, for example, demonstrates that partners' attachment orientations are associated with emotion-regulation processes within relationships and can influence responses to interpersonal vulnerability [24]. These relational aspects should not be understood as diagnostic criteria for sexual dysfunction but may be relevant to broader clinical formulation and intervention.

Shame and avoidance illustrate how individual experiences of sexual distress can acquire interpersonal dimensions. Brotto et al. [3] describe associations between negative affect, including shame, and sexual arousal and desire through processes such as attentional disruption, threat monitoring, and heightened self-evaluation. From a systemic perspective,

individual experiences of shame or avoidance may also have interpersonal consequences. Withdrawal from sexual interaction can be interpreted by a partner as rejection or diminished attraction, potentially contributing to reciprocal patterns of reassurance-seeking, withdrawal, or relational tension. Approach–avoidance models similarly suggest that sexual behavior may be motivated by the pursuit of intimacy and pleasure or by efforts to avoid conflict, guilt, or partner dissatisfaction [26]. When avoidance motives predominate, sexual interaction may be experienced as obligatory rather than mutually desired, with potential implications for sexual and relational satisfaction.

Trauma histories provide another important context for understanding sexual distress. Survivors of childhood sexual abuse and other relational trauma may experience difficulties involving desire, arousal, avoidance, or emotional safety during sexual interaction. Gewirtz-Meydan [27] proposes a functional interpretation in which some sexual difficulties among survivors of childhood sexual abuse may serve protective or regulatory purposes rather than representing only pathological deficits. Within this framework, sexual avoidance can be conceptualized as one means of regulating distress associated with traumatic experiences. Such an interpretation is not a DSM-5-TR diagnostic principle but illustrates how trauma-informed and systemic perspectives may contribute to case formulation when trauma history is clinically relevant.

Sexual experiences are also interpreted through cultural and relational meanings. Gender norms, religious teachings, and cultural expectations concerning desire, availability, and relational roles can contribute to sexual scripts through which individuals and partners interpret sexual experiences. Within Sexual Integration Theory, Fous et al. [28] conceptualize sexual well-being in relation to agency, embodied experience, relational meaning, and other dimensions of sexual health. From this perspective, tensions between personal sexual experience and internalized expectations may be relevant to understanding sexual distress and identifying appropriate areas for clinical assessment.

Considered together, this literature supports attention to relational and contextual aspects of sexual distress as part of comprehensive case formulation. Attachment processes, communication patterns, shame, avoidance, trauma histories, and cultural sexual scripts may influence how sexual difficulties are experienced, interpreted, and negotiated within intimate relationships [3,24–28]. These factors should not be treated as direct evidence for Unspecified Sexual Dysfunction or any other DSM-5-TR diagnosis. Rather, relational and systemic assessment can complement diagnostic evaluation by identifying clinically relevant aspects of sexual distress that may inform treatment planning and interdisciplinary intervention.

8. Treatment Evidence and Clinical Implications

Treatment approaches for sexual dysfunction include pharmacological, psychosexual, behavioral, and relational interventions. Available evidence indicates that treatment selection depends on the nature of the sexual difficulty, contributing factors, and clinical context [13,29–32]. The treatment literature therefore provides additional support for multidimensional assessment and individualized treatment planning.

8.1. Pharmacological and Medical Treatments

Pharmacological interventions are central to treatment for some forms of sexual dysfunction, particularly when physiological mechanisms are prominent. Phosphodiesterase type-5 inhibitors such as sildenafil have demonstrated efficacy in treating erectile dysfunction by improving vascular response and erectile function [29]. Pharmacological treatments targeting hormonal or neurochemical processes have also been examined for disorders

involving sexual desire and arousal [30]. These interventions can produce meaningful improvements when relevant biological mechanisms are present.

Improvement in physiological functioning, however, does not necessarily correspond with improvement across other dimensions of sexual well-being [30]. In a prospective study of men successfully treated with sildenafil, nearly one-third discontinued medication despite its effectiveness, with commonly reported reasons including lack of opportunity for sexual activity or lack of partner interest rather than medication side effects or cost [31]. These findings illustrate that treatment use and outcomes can be influenced by interpersonal and contextual factors even when a pharmacological intervention successfully addresses physiological functioning. Medical treatment may therefore be complemented by psychosocial or relational assessment when such factors are clinically relevant.

8.2. Psychosexual and Behavioral Therapies

Psychosexual interventions include cognitive-behavioral, mindfulness-based, and psychoeducational approaches that address processes such as performance anxiety, attentional focus, negative self-evaluation, and affect regulation. Such approaches have demonstrated benefits across multiple areas of sexual functioning, including desire, arousal, orgasmic function, and sexual pain [13]. Mindfulness-based interventions, for example, seek to reduce self-monitoring and negative evaluation while increasing present-moment and embodied awareness during sexual activity [13]. These approaches illustrate how psychological processes can represent relevant targets of intervention alongside medical or physiological considerations.

8.3. Relational and Couple-Based Interventions

Relational and couple-based interventions address communication, intimacy, and interpersonal aspects of sexual distress. Group-based and relational therapeutic models have demonstrated improvements across domains including desire, arousal, pain, and sexual satisfaction [32]. Such interventions may also provide opportunities to normalize sexual concerns, address shame or isolation, and examine interpersonal patterns relevant to sexual well-being.

Relational models of sexual response provide one framework for understanding these interventions. Within Basson's [33] nonlinear model of female sexual response, desire, arousal, emotional intimacy, and relational satisfaction are conceptualized as interrelated rather than as necessarily occurring in a fixed sequential progression. Sexual motivation may therefore be associated with relational closeness and emotional connection in some presentations. Such models provide a conceptual basis for considering relational context when it is relevant to assessment and treatment.

8.4. Multidimensional Treatment Planning

Combined, these treatment studies support matching intervention to factors identified through comprehensive assessment rather than assuming a single treatment pathway across sexual dysfunctions. Medical, psychological, behavioral, relational, and sociocultural considerations may each be relevant to treatment planning depending on the individual presentation. For patients receiving an Unspecified Sexual Dysfunction diagnosis, broader case formulation may complement diagnostic classification by identifying clinically relevant treatment targets without treating those factors as criteria for the diagnosis.

9. Unspecified Sexual Dysfunction and Comprehensive Clinical Assessment

Unspecified Sexual Dysfunction provides a residual classification for presentations in which symptoms characteristic of sexual dysfunction cause clinically significant distress but

do not meet the full criteria for a specific disorder within the sexual dysfunctions diagnostic class and the clinician does not specify the reason criteria are not met [1]. The category also includes situations in which insufficient information is available to make a more specific diagnosis. It therefore allows clinically significant presentations to be represented within the DSM-5-TR without requiring assignment to a more specific category when available information or diagnostic criteria do not support doing so. The use of an unspecified diagnosis, however, does not eliminate the need for differential assessment or broader clinical formulation.

Diagnostic assessment requires consideration of whether symptoms are better explained by another mental disorder, severe relationship distress or other significant stressors, substance or medication effects, or medical conditions, as specified for the relevant sexual dysfunction diagnosis [1]. Sexual concerns involving desire, arousal, orgasm, or pain may occur alongside endocrine changes, chronic illness, medication effects, psychiatric conditions, trauma histories, or other clinically relevant factors. Sexual concerns may also be under-assessed or inconsistently documented in routine care, where symptoms can be recorded descriptively without comprehensive differential evaluation [34]. Careful assessment can therefore help determine whether a more specific diagnosis is warranted and identify medical, psychological, or contextual aspects relevant to case formulation and treatment.

Trauma-informed and relational frameworks identify additional aspects that may be relevant to clinical formulation. Gewirtz-Meydan [27], for example, proposes that some sexual difficulties among survivors of childhood sexual abuse may be understood functionally as protective or regulatory responses. Other literature identifies trauma-related avoidance, shame, attachment processes, communication patterns, and culturally mediated sexual scripts as potentially relevant to the experience of sexual distress [27,35]. These formulations represent theoretical and clinical perspectives rather than DSM-5-TR diagnostic concepts and should not be interpreted as direct evidence for assigning an Unspecified Sexual Dysfunction diagnosis.

When an Unspecified Sexual Dysfunction diagnosis is used, broader assessment might nevertheless be clinically valuable. Biological, psychological, relational, sociocultural, and developmental aspects may contribute information relevant to case formulation and treatment planning even when they do not determine diagnostic classification. Systemic and relational assessment can therefore complement DSM-5-TR diagnosis by identifying interpersonal and contextual aspects that may be appropriate targets for intervention. In this sense, diagnostic classification and comprehensive case formulation serve complementary purposes: the former identifies the appropriate diagnostic category, whereas the latter helps clinicians understand the broader clinical context in which sexual distress is experienced and treated.

10. Relational and Developmental Contexts of Sexual Well-Being

Beyond the six major categories organizing the literature, a seventh, generative category emerged across them: relational communication and relational development. Unlike the preceding categories, which organize evidence concerning classification, contributors to sexual functioning, and intervention, this category draws attention to processes that cut across those domains and unfold through interaction and over time. Relational context represents one dimension of broader clinical formulation in sexual health. Research on sexuality within intimate relationships identifies associations among sexual functioning, attachment, emotional communication, and interpersonal meaning-making [36]. Communication difficulties and unresolved interpersonal conflict have similarly been associated with sexual dissatisfaction and dysfunction [37]. These findings do not establish rela-

tional processes as diagnostic criteria or causes of sexual dysfunction [38]; rather, they support considering relational context when it is relevant to understanding a patient's sexual experiences and treatment needs.

Sexual satisfaction is also associated with broader dimensions of relational and individual well-being, including relationship satisfaction and emotional closeness [39]. Desire discrepancies, differences in preferred sexual frequency, and divergent expectations regarding sexual initiation can produce distress even when neither partner meets criteria for a specific sexual dysfunction. Cultural expectations concerning how often partners should engage sexually, who should initiate intimacy, or what sexual desire should look like may further shape how such differences are interpreted. Sexual distress and diagnostic sexual dysfunction should therefore not be treated as interchangeable constructs.

Communication may be particularly relevant to the relational experience of sexual well-being. Disclosure of sexual desires, preferences, and concerns has been associated with relational intimacy and sexual satisfaction, whereas difficulty communicating about sexuality may contribute to misunderstanding or dissatisfaction. Holistic approaches to sexuality similarly conceptualize communication and relational meaning-making as components of sexual well-being [40]. Such perspectives provide additional frameworks for clinical formulation without redefining DSM-5-TR diagnostic criteria.

Developmental and life-course contexts may also influence sexual experiences and distress. Sexuality changes alongside biological development, relationship transitions, health conditions, and changing social roles. Transitions involving parenthood, caregiving, employment, illness, and aging may alter established patterns of intimacy and require partners to renegotiate expectations regarding sexuality and emotional connection. Ecological models of sexual development similarly emphasize interacting biological, psychological, relational, and sociocultural influences across time [41]. Developmental context may therefore provide clinically relevant information when assessing changes in sexual functioning without itself indicating the presence of a sexual dysfunction.

The distinction between sexual distress and diagnostic classification is also evident in epidemiological research. In a nationally representative study of midlife women, approximately one-quarter of participants met criteria for sexual dysfunction, while a similar proportion reported clinically significant sexual distress without meeting criteria for a specific disorder [42]. Such findings underscore that clinically meaningful sexual distress does not necessarily correspond to a specific sexual dysfunction diagnosis. Relational and developmental assessment can therefore complement diagnostic evaluation by identifying aspects of sexual well-being and distress that may be relevant to case formulation and intervention even when they do not determine diagnostic classification.

11. Discussion

The literature reviewed here supports a distinction between diagnostic classification and comprehensive clinical formulation in the assessment and treatment of sexual distress. DSM-5-TR classification provides criteria for determining whether a presentation warrants a specific, other specified, or unspecified sexual dysfunction diagnosis, whereas broader clinical formulation considers biological, psychological, relational, sociocultural, and developmental aspects that may be relevant to understanding and treating the presentation. These functions are complementary rather than interchangeable. Relational distress, attachment processes, trauma-related avoidance, communication difficulties, and sociocultural expectations do not constitute diagnostic criteria for Unspecified Sexual Dysfunction; however, the literature reviewed here indicates that such aspects may be clinically relevant to how sexual distress is experienced, assessed, and treated [3,24–28].

From this perspective, Unspecified Sexual Dysfunction need not be interpreted as evidence of inadequacy in categorical classification. The residual category provides a mechanism within DSM-5-TR for representing clinically significant presentations when a more specific sexual dysfunction diagnosis is not assigned. Appropriate diagnostic classification, however, does not exhaust the clinical task. Comprehensive assessment may additionally identify medical, psychological, interpersonal, cultural, or developmental aspects relevant to the patient's sexual distress and determine which may represent appropriate targets for intervention. Systemic assessment can therefore complement diagnostic classification without redefining the criteria or meaning of the diagnosis.

Treatment evidence further supports the value of distinguishing diagnosis from broader clinical formulation. Pharmacological interventions may address physiological mechanisms, psychosexual interventions may target cognitive-affective processes, and relational interventions may address interpersonal aspects relevant to sexual well-being [13,29–33]. The usefulness of interventions operating across these different domains suggests that treatment planning may appropriately extend beyond the information communicated by a diagnostic label. A multidimensional approach can therefore preserve diagnostic precision while allowing clinical formulation and intervention to respond to the broader contexts in which sexual distress is experienced.

12. Implications for Comprehensive Clinical Assessment

The findings of this review support distinguishing DSM-5-TR diagnostic assessment from broader clinical formulation when evaluating sexual distress. Diagnostic assessment determines whether symptoms satisfy criteria for a specific sexual dysfunction or whether another classification, including Other Specified or Unspecified Sexual Dysfunction, is appropriate. Comprehensive clinical assessment can additionally examine biological, psychological, relational, sociocultural, and developmental aspects that may be relevant to understanding the presentation and planning treatment. These processes are complementary: broader assessment need not alter the diagnostic classification to provide clinically useful information.

Integrative and systemic frameworks offer several domains that may inform this broader assessment. Sex-positive therapeutic approaches, for example, consider experiences such as shame, trauma, fear, embodied experience, and interpersonal dynamics when these are relevant to sexual well-being [28]. Relational assessment may similarly examine communication about sexuality, differences in desire or expectations, attachment and emotional-regulation processes, and the effects of developmental or relationship transitions. These factors are not diagnostic criteria for Unspecified Sexual Dysfunction but may identify clinically relevant treatment needs that are not communicated by the diagnostic label alone (see Table 2 for example domains and clinical questions).

Comprehensive assessment can therefore extend beyond symptom classification while preserving the integrity of DSM-5-TR diagnostic criteria. When an Unspecified Sexual Dysfunction diagnosis is appropriate, additional assessment may help identify medical, psychological, relational, developmental, or sociocultural aspects relevant to intervention without implying that these factors constitute the diagnosis itself. Such assessment complements rather than replaces psychiatric evaluation and may support treatment planning and interdisciplinary collaboration among psychiatry, sexual medicine, psychotherapy, and systemic or couple-based care.

Table 2. Domains for Comprehensive Assessment of Sexual Distress.

Assessment Domain	Example Clinical Questions
Sexual functioning	When did the sexual concerns begin? Are they consistent across partners, situations, or contexts?
Medical and pharmacological factors	Are relevant medical conditions, medications, hormonal changes, or substance-related factors present?
Relational context	How are intimacy, sexual needs, and differences in desire communicated and negotiated?
Emotional and trauma-related context	Are shame, anxiety, trauma history, or emotional regulation relevant to the presenting concern?
Developmental context	Have life transitions such as parenthood, illness, caregiving, or aging affected sexual experiences or intimacy?
Sociocultural context	What beliefs, norms, identities, or expectations shape the individual's or partners' understanding of sexual experiences?

13. Limitations

Several limitations should be considered when interpreting this review. As a narrative rather than systematic review, the search was designed to support interdisciplinary conceptual synthesis rather than exhaustive identification or quantitative aggregation of the available evidence. The search relied primarily on Google Scholar, supplemented by citation-network mapping through Research Rabbit, and therefore may not have identified relevant publications available through other databases, grey literature, or alternative search strategies. Source screening and selection were conducted by a single author, and the final corpus of 34 publications reflects judgments regarding relevance to the review question. The review may therefore be subject to selection and publication biases, and no formal systematic-review risk-of-bias assessment was conducted.

The included literature also represents heterogeneous disciplinary, methodological, diagnostic, and theoretical traditions, limiting direct comparison across studies. Accordingly, the synthesis should not be interpreted as establishing prevalence, comparative treatment efficacy, causal relationships, or superiority of systemic approaches over other assessment or intervention models. Rather, the review identifies clinically relevant literature across diagnostic, biopsychosocial, relational, and treatment domains and considers how these perspectives may inform comprehensive clinical formulation. Future systematic or scoping reviews using multiple databases and formal evidence-appraisal procedures could more comprehensively evaluate specific diagnostic, assessment, or treatment questions identified by this narrative synthesis.

14. Future Directions

Several directions for future research emerge from this review. First, research should further examine how diagnostic classification and multidimensional clinical formulation operate together in the assessment of sexual distress. Studies examining associations among biological and psychological factors, communication, attachment, relational expectations, sociocultural context, and sexual well-being could clarify which aspects are most relevant to particular clinical presentations and treatment needs. Such research may also help distinguish factors relevant to DSM-5-TR diagnostic decision-making from those that primarily inform broader case formulation.

Second, further work could develop and evaluate structured approaches to comprehensive sexual health assessment. Multisystemic frameworks already emphasize integration of biological, psychological, relational, and cultural domains in clinical formulation [38].

Research could evaluate whether multidimensional assessment approaches improve identification of clinically relevant factors, treatment selection, interdisciplinary referral, or patient outcomes. Such work should distinguish assessment intended to establish a diagnosis from assessment intended to inform case formulation and intervention.

Third, additional research should examine when relational and couple-based interventions are beneficial for individuals experiencing sexual distress and how these approaches may complement medical, pharmacological, and psychosexual treatments. Comparative and integrative treatment studies could identify which interventions, or combinations of interventions, are most appropriate for particular presentations. Research examining collaboration among psychiatry, sexual medicine, sex therapy, and relational therapy may likewise clarify the potential benefits of interdisciplinary care.

Finally, empirical research is needed on how Unspecified Sexual Dysfunction is used in clinical practice. Studies of diagnostic decision-making could examine the circumstances under which clinicians select Unspecified rather than Other Specified Sexual Dysfunction or a specific sexual dysfunction diagnosis, the role of insufficient clinical information in that decision, and the assessment procedures that precede classification. Longitudinal research could further examine whether an initial unspecified diagnosis remains stable or changes following additional assessment and what treatment pathways follow its use. Such evidence could inform clinical guidance and, where warranted by empirical findings, future consideration of sexual dysfunction classification.

15. Conclusions

Unspecified Sexual Dysfunction serves a defined function within the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* by providing a classification for clinically significant presentations that do not meet criteria for a specific sexual dysfunction when the clinician does not specify the reason, including situations in which insufficient information is available for a more specific diagnosis. The broader literature reviewed here also demonstrates that sexual functioning and sexual distress may involve biological, psychological, relational, sociocultural, and developmental aspects [43,44]. These aspects should not be construed as diagnostic criteria for Unspecified Sexual Dysfunction, but they may remain clinically relevant after an appropriate diagnostic classification has been established.

Diagnostic classification and comprehensive clinical formulation therefore answer related but distinct clinical questions. DSM-5-TR criteria guide determination of the appropriate diagnostic classification, whereas broader assessment can identify medical, psychological, interpersonal, cultural, and developmental aspects relevant to understanding the presentation and selecting appropriate interventions. Systemic and relational perspectives can contribute to this broader formulation by examining communication, relational context, trauma history, emotional regulation, and sexual meaning when these aspects are relevant to the individual presentation.

Comprehensive assessment thus complements rather than replaces psychiatric diagnosis. Integrating diagnostic evaluation with broader clinical formulation may support individualized treatment planning and interdisciplinary collaboration across psychiatry, sexual medicine, psychosexual therapy, and relational or systemic care. For patients experiencing clinically significant sexual distress, preserving diagnostic precision while attending to the broader contexts of sexual well-being offers a clinically useful approach to assessment and intervention.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Conflicts of Interest: The author declares no conflicts of interest.

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.; American Psychiatric Pub: Arlington, VA, USA, 2022.
2. Bhugra, D.; Colombini, G. Sexual dysfunction: Classification and assessment. *Adv. Psychiatr. Treat.* **2013**, *19*, 48–55. [CrossRef]
3. Brotto, L.; Atallah, S.; Johnson-Agbakwu, C.; Rosenbaum, T.; Abdo, C.; Byers, E.S.; Graham, C.; Nobre, P.; Wylie, K. Psychological and Interpersonal Dimensions of Sexual Function and Dysfunction. *J. Sex. Med.* **2016**, *13*, 538–571. [CrossRef]
4. McCabe, M.P.; Sharlip, I.D.; Atalla, E.; Balon, R.; Fisher, A.D.; Laumann, E.; Lee, S.W.; Lewis, R.; Segraves, R.T. Definitions of Sexual Dysfunctions in Women and Men: A Consensus Statement from the Fourth International Consultation on Sexual Medicine 2015. *J. Sex. Med.* **2016**, *13*, 135–143. [CrossRef]
5. Parish, S.J.; Goldstein, A.T.; Goldstein, S.W.; Goldstein, I.; Pfaus, J.; Clayton, A.H.; Giraldi, A.; Simon, J.A.; Althof, S.E.; Bachmann, G.; et al. Toward a More Evidence-Based Nosology and Nomenclature for Female Sexual Dysfunctions—Part II. *J. Sex. Med.* **2016**, *13*, 1888–1906. [CrossRef]
6. Galvan, M.C.; Galvan, J.L. *Writing Literature Reviews: A Guide for Students of the Social and Behavioral Sciences*, 8th ed.; Routledge: Abingdon, UK, 2024.
7. Jahan, N.; Naveed, S.; Zeshan, M.; Tahir, M.A. How to Conduct a Systematic Review: A Narrative Literature Review. *Cureus* **2016**, *8*, e864. [CrossRef]
8. Calero-Medina, C.; Noyons, E.C. Combining mapping and citation network analysis for a better understanding of the scientific development: The case of the absorptive capacity field. *J. Informetr.* **2008**, *2*, 272–279. [CrossRef]
9. Simons, J.S.; Carey, M.P. Prevalence of Sexual Dysfunctions: Results from a Decade of Research. *Arch. Sex. Behav.* **2001**, *30*, 177–219. [CrossRef]
10. Rosen, R.C.; Fisher, W.A.; Eardley, I.; Niederberger, C.; Nadel, A.; Sand, M. The multinational Men's Attitudes to Life Events and Sexuality (MALES) study: I. Prevalence of erectile dysfunction and related health concerns in the general population. *Curr. Med. Res. Opin.* **2004**, *20*, 607–617. [CrossRef]
11. Lewis, R.W.; Fugl-Meyer, K.S.; Bosch, R.; Fugl-Meyer, A.R.; Laumann, E.O.; Lizza, E.; Martin-Morales, A. Epidemiology/Risk Factors of Sexual Dysfunction. *J. Sex. Med.* **2004**, *1*, 35–39. [CrossRef]
12. Lewis, R.W.; Fugl-Meyer, K.S.; Corona, G.; Hayes, R.D.; Laumann, E.O.; Moreira, E.D., Jr.; Rellini, A.H.; Segraves, T. Definitions/epidemiology/risk factors for sexual dysfunction. *J. Sex. Med.* **2010**, *7*, 1598–1607. [CrossRef]
13. Weinberger, J.M.; Houman, J.; Caron, A.T.; Anger, J. Female Sexual Dysfunction: A Systematic Review of Outcomes Across Various Treatment Modalities. *Sex. Med. Rev.* **2019**, *7*, 223–250. [CrossRef]
14. Parish, S.J.; Meston, C.M.; Althof, S.E.; Clayton, A.H.; Goldstein, I.; Goldstein, S.W.; Heiman, J.R.; McCabe, M.P.; Segraves, R.T.; Simon, J.A. Toward a More Evidence-Based Nosology and Nomenclature for Female Sexual Dysfunctions—Part III. *J. Sex. Med.* **2019**, *16*, 452–462. [CrossRef]
15. Parish, S.J.; Cottler-Casanova, S.; Clayton, A.H.; McCabe, M.P.; Coleman, E.; Reed, G.M. The Evolution of the Female Sexual Disorder/Dysfunction Definitions, Nomenclature, and Classifications: A Review of DSM, ICSM, ISSWSH, and ICD. *Sex. Med. Rev.* **2021**, *9*, 36–56. [CrossRef]
16. Hatzimouratidis, K.; Hatzichristou, D. Sexual Dysfunctions: Classifications and Definitions. *J. Sex. Med.* **2007**, *4*, 241–250. [CrossRef]
17. Fisher, W.A.; Gruenwald, I.; Jannini, E.A.; Lev-Sagie, A.; Lowenstein, L.; Pyke, R.E.; Reisman, Y.; Revicki, D.A.; Rubio-Aurioles, E. Standards for clinical trials in male and female sexual dysfunction IV: Unique aspects of clinical trials in female sexual dysfunction. *J. Sex. Med.* **2017**, *14*, 19–26. [CrossRef]
18. Gonsalves, L.; Cottler-Casanova, S.; VanTreeck, K.; Say, L. Results of a World Health Organization Scoping of Sexual Dysfunction–Related Guidelines: What Exists and What Is Needed. *J. Sex. Med.* **2020**, *17*, 2518–2521. [CrossRef]
19. Davis, S.R. Sexual dysfunction in women. *N. Engl. J. Med.* **2024**, *391*, 736–745. [CrossRef]
20. Heiman, J.R. Sexual dysfunction: Overview of prevalence, etiological factors, and treatments. *J. Sex Res.* **2002**, *39*, 73–78. [CrossRef]
21. DeRogatis, L.R.; Burnett, A.L. The epidemiology of sexual dysfunctions. *J. Sex. Med.* **2008**, *5*, 289–300. [CrossRef]
22. Jaworski, M. Is sexology necessary in dermatology? Review of most common sexual dysfunction in skin disorders. *Our Dermatol. Online* **2017**, *8*, 341–347. [CrossRef]
23. Ghadigaonkar, D.S.; Murthy, P. Sexual Dysfunction in Persons With Substance Use Disorders. *J. Psychosexual Health* **2019**, *1*, 117–121. [CrossRef]

24. Brandão, T.; Matias, M.; Ferreira, T.; Vieira, J.; Schulz, M.S.; Matos, P.M. Attachment, emotion regulation, and well-being in couples: Intrapersonal and interpersonal associations. *J. Pers.* **2020**, *88*, 748–761. [CrossRef]
25. Coffelt, T.A.; Hess, J.A. Sexual Disclosures: Connections to Relational Satisfaction and Closeness. *J. Sex Marital. Ther.* **2014**, *40*, 577–591. [CrossRef]
26. Gable, S.L.; Impett, E.A. Approach and Avoidance Motives and Close Relationships. *Soc. Pers. Psychol. Compass* **2012**, *6*, 95–108. [CrossRef]
27. Gewirtz-Meydan, A. Sexual Dysfunction Among Childhood Sexual Abuse Survivors: The "Functional" Dysfunction? *J. Sex Marital. Ther.* **2022**, *48*, 694–705. [CrossRef]
28. Fous, G.; Bazzaroni, C.; Needle, R.; Favasuli, S. Sexual Integration Therapy: A sex-positive sexual health model supporting authentic sexual expression, while addressing sexual compulsivity, shame, fear and trauma. *Sex. Relatsh. Ther.* **2025**, *40*, 747–772. [CrossRef]
29. Ciocanel, O.; Power, K.; Eriksen, A. Interventions to Treat Erectile Dysfunction and Premature Ejaculation: An Overview of Systematic Reviews. *Sex. Med.* **2019**, *7*, 251–269. [CrossRef]
30. Kingsberg, S.A.; Woodard, T. Female sexual dysfunction: Focus on low desire. *Obstet. Gynecol.* **2015**, *125*, 477–486.
31. Klotz, T.; Mathers, M.; Klotz, R.; Sommer, F. Why do patients with erectile dysfunction abandon effective therapy with sildenafil (Viagra®)? *Int. J. Impot. Res.* **2005**, *17*, 2–4. [CrossRef]
32. Bonato, F.R.C.; Mussi, A.; Genez, L.F.; Pellizzer, C.M.N.; Cardoso, N.d.O. Efficacy of Group Psychotherapies for the Treatment of Female Sexual Dysfunction: A Systematic Review. *Trends Psychol.* **2024**, 1–20. [CrossRef]
33. Basson, R. Women's sexual dysfunction: Revised and expanded definitions. *Can. Med. Assoc. J.* **2005**, *172*, 1327–1333. [CrossRef]
34. Heiden-Rootes, K.M.; Salas, J.; Gebauer, S.; Witthaus, M.; Scherrer, J.; McDaniel, K.; Carver, D. Sexual dysfunction in primary care: An exploratory descriptive analysis of medical record diagnoses. *J. Sex. Med.* **2017**, *14*, 1318–1326. [CrossRef]
35. Gewirtz-Meydan, A.; Opuda, E. The Impact of Child Sexual Abuse on Men's Sexual Function: A Systematic Review. *Trauma Violence Abus.* **2022**, *23*, 265–277. [CrossRef]
36. Impett, E.A.; Muise, A.; Peragine, D. Sexuality in the context of relationships. In *APA Handbook of Sexuality and Psychology: Person-Based Approaches*; Tolman, D.L., Diamond, L.M., Bauermeister, J.A., George, W.H., Pfaus, J.G., Ward, L.M., Eds.; American Psychological Association: Washington, DC, USA, 2014; Volume 1, pp. 269–315.
37. Marciante, N. Communication disorders, interpersonal conflicts and sexual dysfunctions: New perspectives on sex therapy. *Pragmat. Cogn.* **2016**, *23*, 501–504.
38. Breunlin, D.C.; Pinsof, W.; Russell, W.P. Integrative Problem-Centered Metaframeworks Therapy I: Core Concepts and Hypothesizing. *Fam. Process* **2011**, *50*, 293–313. [CrossRef]
39. Diamond, L.M.; Huebner, D.M. Is Good Sex Good for You? Rethinking Sexuality and Health. *Soc. Pers. Psychol. Compass* **2012**, *6*, 54–69. [CrossRef]
40. Manning, J. Communication and healthy sexual practices: Toward a holistic communicology of sexuality. In *Applications in Health Communication: Emerging Trends*; Eaves, M.H., Ed.; Kendall-Hunt: Dubuque, IA, USA, 2014; pp. 263–286.
41. Jones, K.E.; da Silva, A.M.M.; Soloski, K.L. Sexological Systems Theory: An ecological model and assessment approach for sex therapy. *Sex. Relatsh. Ther.* **2011**, *26*, 127–144. [CrossRef]
42. Wang, Y.; Islam, R.M.; Bond, M.; Skiba, M.A.; Davis, S.R. Sexual dysfunction in women at midlife: A cross-sectional study of data from the Australian Women's Midlife Years study. *Lancet Obstet. Gynaecol. Women's Health* **2025**, *1*, e198–e208. [CrossRef]
43. Tiefer, L. "Am I normal?" The question of sex. In *Sex Is Not a Natural Act & Other Essays*, 2nd ed.; Routledge: Abingdon, UK, 2018; pp. 5–14.
44. Sungur, M.Z.; Gündüz, A. A Comparison of DSM-IV-TR and DSM-5 Definitions for Sexual Dysfunctions: Critiques and Challenges. *J. Sex. Med.* **2014**, *11*, 364–373. [CrossRef]

Disclaimer/Publisher's Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.