

Female Orgasmic Disorder

Background

1. Definition

- Formerly known as Inhibited Female Orgasm
- Also called anorgasmia
- Lack of orgasm, marked delay of orgasm, or diminished sensation/intensity of orgasm in presence of high sexual arousal/excitement or marked delay of orgasm from any kind of stimulation
- Sufficient sexual stimulation is a prerequisite
- Only diagnosed if causes distress
- Condition can be further categorized:
 - Generalized or situational, lifelong (primary) or acquired (secondary)

2. General info

- Orgasms may become shorter in duration or less intense with aging
- From DSM-IV-TR
 - "Once a female learns how to reach orgasm, it is uncommon for her to lose that capacity, unless poor sexual communication, relationship conflict, a traumatic experience (e.g., rape), a Mood Disorder, or a general medical condition intervenes."
- Cannot diagnose in the presence of Female Sexual Arousal Disorder
 - Normal sexual excitement phase is a prerequisite
- May occur in association with other sexual dysfunctions

Pathophysiology

1. Pathology of disease

- Organic / psychologic
- Lifelong orgasmic dysfunction
 - Usually associated with lack of knowledge about sexual functioning and/or genital anatomy
- Acquired orgasmic dysfunction
 - Usually associated with medication side effects, illness, or relational disturbance

2. Incidence, prevalence

- 26% of US women 18-59% report orgasmic difficulty within the past 12 months²
- 33-38% of women over age 57 report difficulty with orgasm³
- DSM-IV estimates 5-42% in the primary care setting

3. Risk factors

- Psychological
 - Depression
 - Reduced sexual knowledge
 - Partner/relationship related factors (abuse, negative feelings, reduced attraction, partner sexual dysfunction)
 - Privacy concerns
 - Risk concerns (STDs, pregnancy)

- Social/cultural/spiritual concerns (shame, sexual expectations)
- Low self-esteem
- Non-sexual anxiety/concerns (e.g., financial, family, work difficulties)
- Biological
 - Medication effects
 - Spinal cord injury
 - Debility
 - Lack of ovarian androgen
 - Hypothyroidism
 - Hyperprolactinemia
- Associated features:
 - (These features do not, alone, differentiate anorgasmic from orgasmic women)
 - Decreased education
 - Low income
 - Impaired health
 - Personal unhappiness
 - Younger age
 - Marital status (higher in divorced women)
 - Race (higher in African-American women)
 - Higher religiosity
 - Infrequent sexual activity
 - Infrequent sexual thoughts
 - Being sexually touched before puberty

Diagnostics

1. History

- Current sexual context
 - Problem situational or generalized; primary or secondary
 - Orgasm with masturbation
 - Adequacy of stimulation
 - Adequate physiological and psychological arousal
 - Adequate interest
 - Agreement with partner about sexual practices
 - Sexual communication with partner
 - Adequate privacy
 - Partner's sexual functioning
 - Relationship status outside of sexual concerns
 - Energy level/fatigue
 - Gender identity/sexual orientation
 - Sexual self-image
 - Physical problems or pain impeding sexual behavior
 - Anorgasmia concerns self, partner, or both
- Historical sexual context
 - Orgasm history
 - Negative past sexual experiences/abuse
 - Physical/verbal/emotional abuse in past

- Concurrent co-morbid conditions
 - Depression /other psychiatric disorders
 - Physical debility
 - Spinal cord injury (especially upper motor neuron lesion)
 - Multiple sclerosis
 - Lower urinary tract infection
 - Hypothyroidism
 - Hyperprolactinemia
 - Significantly diminished ability to reach orgasm among women on maintenance hemodialysis⁴
 - Hypotonicity of the pelvic floor muscles
- 2. Past medical history
 - History of hysterectomy, gynecological malignancies and breast cancer
 - Post menopausal state/hypoestrogen state
 - History of CVA⁵
- 3. Medications use
 - SSRIs
 - Most common
 - Strongly dose-related
 - Antipsychotics
 - Clonidine
 - Benzodiazepines
 - Methyldopa
 - Methadone
 - Amphetamines
 - Trazodone
 - Tricyclic Antidepressants
- 4. Physical exam
 - Physical examination often normal
 - Complete examination with focused pelvic examination can facilitate patient education and reassurance⁶
 - Examine for evidence of neuropathy, hypotonicity of pelvic floor muscles
 - Laboratory evaluation
 - No routine labs recommended
 - Guided by the history and general medical condition
- 5. DSM-IV-TR Criteria for Female Orgasmic Disorder
 - Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase, in the presence of adequate sexual stimulation
 - Disturbance causes marked distress or interpersonal difficulty
 - Not better accounted for by another Axis I disorder
 - Not due exclusively to the direct physiological effects of a substance or general medical condition

Differential Diagnosis

1. Depression
2. Adverse medication reaction
3. Hypothyroidism
4. Female Sexual Arousal Disorder

- 5. Hypoactive Sexual Desire Disorder
- 6. Dyspareunia
- 7. Sexual aversion disorder
- 8. Vaginismus

Therapeutics⁷

1. Acute treatment

- Patient and partner education (resource: Becoming Orgasmic- see below) may be an adequate intervention for primary anorgasmia⁸
- Emphasize importance of foreplay
- Maximize psychological stimulation (through fantasy development; auditory/visual stimuli, etc.)
- Maximize physical stimulation
 - Use of vibrators, prolonged masturbation, "coital alignment"⁹
- EROS-CTD (clitoral therapy device)
 - Battery powered device, available by prescription, produces a gentle vacuum over clitoris
 - Aids clitoral engorgement, vaginal lubrication, orgasm in several small pilot studies¹⁰
 - May help patients who have failed to benefit from interventions employing manual self-stimulation or vibrators
 - No controlled studies specific to orgasmic dysfunction
- Directed masturbation
 - Taught by a clinician or through patient self-help materials has been shown to be effective in teaching women the "skill" of orgasm^{11,12}
 - 70-90% of women with lifelong anorgasmia will be helped by directed masturbation
 - Independent orgasm usually precedes orgasm with partner
 - Increased capacity to achieve orgasm with partner over time
- Kegel exercises
 - Not appear to be effective in increasing orgasm frequency¹³
 - May improve women's comfort with and awareness of their genitals, and may add to the beneficial effect of increasing sexual fantasies¹⁴
- Sensate Focus Technique
 - Series of graded exercises starting with nongenital pleasant touch and increasing to genital stimulation
 - Goal is to increase sexual excitement
 - Initially includes a ban on intercourse and orgasm to reduce performance anxiety
- Pharmacotherapy
 - Bupropion (330 mg/day) may improve orgasmic response in women with hypoactive sexual desire disorder¹⁵
 - Limited evidence suggests possible effectiveness in non-depressed women with orgasmic dysfunction (Bupropion-SR 150 mg/day-300 mg/day)¹⁶
- Bupropion is often used to counteract SSRI induced sexual dysfunction
- No studies specific to female orgasmic difficulty¹⁷

- Use of sildenafil to improve sexual symptoms in premenopausal women is not supported by evidence¹⁸
 - Pilot evidence suggests possible benefit for post-menopausal women with orgasmic dysfunction¹⁹
- Transdermally delivered testosterone may offer some benefit (libido, arousal, and orgasm) to oophorectomized women already being treated with estrogen²⁰

2. Long-term care

- For women able to achieve orgasm via masturbation but not with a partner (and this is desired), couples therapy is indicated
- Cognitive behavioral therapy can be useful for patients with maladaptive beliefs about sexual behavior, fear which impedes ability to progress through recommendations, or unreasonable sexual expectations

Follow-Up

1. Return to office

- Patients should return after an adequate trial of initial recommendation (2-4 weeks)

2. Refer to specialist

- Refer to a competent psychologist/sex therapist if:
 - No response (or distress) to initial intervention
 - Multiple sexual dysfunctions
 - Abuse (current or past)
 - Relational disorder
 - Physician discomfort
 - Physician time constraints
 - For assistance locating a qualified therapist
- American Association of Sexuality Educators Counselors and Therapist <http://www.aasect.org/>
- Association for Behavioral and Cognitive Therapies <http://www.abct.org/>

3. Recommendations

- Second International Consultation on Erectile and Sexual Dysfunctions (2004) summary of findings:²²
 - Directed masturbation is recommended for management of lifelong generalized orgasmic disorder
 - Situational orgasmic disorder may require a focus on relationship
 - No pharmacological treatments can be recommended

Prognosis

1. Prognosis is good with appropriate treatment¹¹
2. Prognosis improved for younger, married, emotionally healthy women²¹

Prevention

1. Adequate sexual knowledge
2. Absence of abuse in childhood/adolescence
3. Appropriate couple communication
4. Lack of shame/guilt re: sexual behavior and body

Patient Education

1. American Family Physician
 - o <http://www.aafp.org/afp/20000701/141ph.html>
2. Becoming Orgasmic: A Sexual and Personal Growth Program for Women. Julia Heiman, Joseph LoPiccolo,. 1987. Fireside. NY.

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Authors: Michele M. Larzelere, PhD, & Dave E. Williams, MD, *LSU FMRP-Kenner, LA*

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