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Orgasmic Disorders

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Synonyms

Anorgasmia; Climax disorder; Delayed ejaculation; Female orgasmic disorder; Inhibited ejaculation; Premature ejaculation

Definition

Difficulty reaching or controlling orgasm by a man or woman. The problem may be characterized by an early, delayed, or absence of orgasm.

Introduction

In both the four-stage model of sexual response first proposed by Masters and Johnson (excitement, plateau, orgasm, resolution) and the three-stage model later adapted by Kaplan (1995) (desire, arousal, orgasm), orgasm represents a reproductive and psycho-behavioral endpoint. In both models, orgasm follows variable periods of intensifying sexual arousal. Both sexes experience intense pleasure throughout the body during orgasm, a phenomenon mediated by brain regions involved with reward and pleasure. Although in men ejaculation nearly always occurs concomitantly with orgasm, women exhibit no comparable external genital response. Women's orgasm is signaled by, among other responses, pelvic and anogenital contractions, typically lasting two to three times longer than men's (Masters and Johnson 1970).

For men, the two most common orgasmic disorders are premature ejaculation (PE; ejaculating shortly after or prior to partner penetration, before the male wishes, and to the point of distress or disruption of his and/or his partner's sexual experiences) and delayed/inhibited ejaculation (IE; difficult or impossible ejaculation and orgasm). Women, by contrast, are characterized by only one orgasmic disorder called female orgasmic disorder (FOD), which is similar to men's IE, as it is characterized by the recurrent difficulty in reaching orgasm after becoming sexually aroused. Each of these disorders is sometimes further categorized as lifelong versus acquired (i.e., after some period of normal function) or situational (in specific circumstances or with a specific partner) versus global (across all circumstances) and may result from a variety of etiologies ranging from biological to psychological or their combination.

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Premature Ejaculation

PE is characterized by ejaculation prior to expectation or desire and usually within a minute or two of penetration. Early studies suggested prevalence rates of 20–30%, but more recent studies using dysfunction-based criteria suggest rates closer to 5–10%. A variety of theories surround the etiology of PE, spanning from physiological and psychological to relational – most likely all are involved, although to different degrees. Contrary to initial suppositions, PE does not appear to be age related (Binik and Hall 2014).

Various physiological or pathophysiological factors may contribute to PE, including a genetic predisposition, an anomalous sympathetic nervous system, a heightened penile sensitivity, medications, or a lower ejaculatory threshold. While all may contribute to PE, no single factor appears most relevant. Rather, an inherent range for ejaculatory latencies exists such that some men are predisposed to ejaculate rapidly after penetration (e.g., within 1–2 min), while others take longer (e.g., 5–10 min), with latency shaped further by contextual factors (e.g., lack of privacy) to better predict the actual timing of ejaculation. Psychological and relationship factors may also play a role in PE, such as social and emotional issues (including anxiety) that contribute to negative and distracting thought patterns during sex that might impair ejaculatory control or difficulties with the partner such as anxiety derived from sexual aversion or lack of interest.

Treatment for PE may involve pharmacological and/or psychosexual strategies, but in either case, as PE is considered a couple's issue, a team approach including the partner is preferred. Pharmacological treatment typically includes daily or on-demand use of low-dose selective serotonergic reuptake inhibitors, similar to antidepressant medications, where discontinuation marks the return of the condition. As an alternative, men could use a condom or apply a local anesthetic (e.g., lidocaine) to their penis, thus attenuating sensory input and increasing the latency to ejaculation. A possible side effect of using local anesthetics includes diminished vaginal sensitivity.

Psychosexual counseling such as cognitive-behavioral techniques (CBT), psychoeducation, and relationship counseling are alternate treatments, with a focus on lowering male sexual arousal and development of greater ejaculatory control. Depending on the severity of the PE condition, these methods may be used in conjunction with pharmacological approaches. Combined psychosexual counseling with pharmacological treatments may improve overall efficacy, enabling couples to quickly gain sexual confidence while learning various psycho-behavioral techniques (Rowland 2012).

Delayed/Inhibited Ejaculation

Inhibited (IE) or delayed ejaculation refers to a man's persistent delay in or absence of orgasm despite adequate sexual stimulation. Normative data suggest that most men ejaculate within about 5–10 min after penetration, and therefore men who take significantly longer or simply give up due to frustration or fatigue may be considered for an IE diagnosis. The prevalence of this dysfunction is estimated to range from 5 to 15%, with an increasing prevalence associated with age (Laumann et al. 1999; Perelman and Rowland 2008).

A variety of pathophysiological and psychological explanations may account for men experiencing IE. Men who have recently acquired IE after some period of normal ejaculatory function may suffer from a pathophysiological origin such as surgical complication in the pelvic region, neuropathy, or endocrine dysfunction. Although pharmacological treatments have not proven effective in treating IE, should any of the man's ongoing medications interfere with ejaculatory response (and many do), the medication could be altered.

Psychological explanations, more relevant to lifelong IE or IE that has developed over a period of years, tend to focus more on attitudes toward sexuality (e.g., a high degree of religious orthodoxy and sexual guilt), inadequate sexual arousal, and anxiety surrounding sexual performance. For example, some men who masturbate frequently

may develop a routine of rapid, stereotypical stimulation that does not replicate stimulation during intercourse. Other men may worry about their ability to satisfy their partner, leading to distraction from erotic sensations that lead to sufficiently intense arousal for ejaculation.

IE may be particularly frustrating when it interferes with a couple's plan for procreation, yet a team (couple) approach carried out with the guidance of a psychosexual counselor can often alleviate the problem. Depending on its etiology, various treatments can be considered, but autoerotic patterns (e.g., masturbation, use of erotic materials), relationship issues (e.g., the man may no longer find his partner sexually attractive), and quality of the couple's communication about sexual stimulation preferences usually need to be assessed. Understanding relationship factors, such as underlying tension between the couple from fear of pregnancy or unresolved anger/resentment toward the partner, is an important precondition to treatment. In such situations the man may be mentally unable to allow himself to ejaculate, so such issues need resolution before other concerns are addressed.

Most IE treatments have the goal of increasing or reestablishing high levels of arousal and/or decreasing anxiety that may distract from erotic stimulation. For example, a man suffering from lifelong IE (fairly rare) must first learn his arousal and ejaculatory patterns and be comfortable communicating these to his partner. This process may include solo and/or mutual masturbation, exploring sexual fantasies together, and transferring the consequent arousal to situations involving intercourse. If the man has previously been able to reach orgasm or is able to do so during masturbation, treatment will likely focus on masturbatory retraining and underlying relational issues. Where, for example, current masturbatory patterns and/or use of erotic/arousing materials is not well aligned with partnered behaviors during intercourse, the clinician may recommend discontinuation or alteration in masturbation patterns in order to increase arousal during intercourse. Because such strategies often focus heavily on providing and sustaining the man's arousal, the partner may sometimes feel that her/his needs are being neglected, but she/he can be counseled that the situation is a temporary strategy to improve sexual satisfaction for both of them. In addition to increasing the man's arousal, focus on anxiety and distraction reduction that typically interfere with arousal typically occurs throughout the treatment process.

Female Orgasmic Disorder

Female orgasmic disorder (FOD) is defined as a woman's difficulty or inability to reach orgasm following adequate sexual arousal. For this diagnosis, the woman must be bothered by the condition, and the inability must be abnormal for the woman's age, sexual experience, and adequacy of stimulation. Regarding this last criterion, as many women who have difficulty reaching orgasm are insufficiently sexually aroused, such women are generally regarded as having an arousal phase issue rather than an orgasm problem. FOD is thought to be the second most frequent female sexual dysfunction, estimated to affect 10–35% of women. Yet only about half of these women report concomitant concern about their condition (Meana 2012).

As with the men's orgasmic phase disorders, a myriad of possible etiologies exists for FOD. Importantly, no easily identifiable cause or causes can be invoked to explain the disorder. However, in contrast with men's sexual disorders, psychological and relationship factors tend to predominate, although biological and pathophysiological factors should not be discounted. Endocrine levels, medical conditions, medications, and surgical side effects all have the potential to affect women's overall health, their general sexual functioning, and the ability to reach orgasm. For example, extreme variation in testosterone levels (very high or very low), menopause status, orgasm-inhibiting medications (e.g., antidepressants), surgical interventions, and various illnesses can affect women's sexual function. Furthermore, such physical conditions may impart psychological effects on mood, anxiety, and self-concept, all of which may reduce sexual interest, engagement, and the potential for sexual arousal. Such

straightforward relationships between psychological issues and sexual functioning can often be identified through clinical investigation. Aging is another biological factor likely to affect sexual and orgasmic response in women, more through sociocultural expectation than the aging process itself. As menopausal changes occur, an agist view deems her reproductively spent, a view that impacts self-esteem, confidence, and a sense of self-efficacy, all of which are important to a sexually satisfying relationship. As with men with IE, no pharmacological treatments are available for FOD. However, if a medication is suspected of inhibiting orgasm, a substitute may be considered.

Aside from biomedical etiologies, a vast number of psychological factors have the potential to impact women's sexual arousal and orgasmic response, some already mentioned above. For example, a woman's self-concept, self-image, and response to general life stressors may affect her sexual functioning, distracting her focus from the erotic stimulation of the sexual experience. Socioculturally derived negative attitudes toward sexuality, depression, and anxiety – whether from sex-specific factors during sex (e.g., pain or discomfort during intercourse) or from broader life challenges – may inhibit women's sexual desire/interest and/or distract them from otherwise pleasurable stimulation during intercourse. Important to most women's sexual engagement and response is the quality of their relationship with their partner – whether they feel comfortable, desired, and a sense of emotional intimacy with him/her. Underlying tension in the relationship and/or feelings of anger toward the partner often act as strong inhibitors of arousal and orgasmic response. Overall, women may attribute their difficulty to a variety of etiologies. These attributions may be complex and sometimes vague, but they often provide an important starting point for treatment.

Psychosexual counseling is usually the most effective treatment for FOD. Clinicians typically use a combination of education, communication improvement, and cognitive-behavioral therapy (CBT), methods that enable the woman to learn more about bodily sensations and pleasure, to reduce anxiety, and to communicate effectively and comfortably with her partner. Effective methods for reducing anxiety – often an important first step – include a progression from pleasurable nonsexual touching to sexual intercourse (sensate focus) or relaxation techniques to work through a hierarchy of anxiety-provoking sexual situations (systematic desensitization). In contrast, directed masturbation training is typically intended to increase sexual arousal by helping the woman identify her pleasure points. Initially done as an exploratory solo exercise, once able to reach an orgasm, the woman communicates with and assists her partner regarding effective ways to maximize arousal. Kegel exercises – the repeated 3-sec tensing and relaxing of the muscles used to stop urinating – can sometimes facilitate movement toward arousal and orgasm in women and so may be considered in conjunction with any of these methods.

Conclusion

Etiology of orgasmic problems may be different for men and women, but for each sex, a mix of physiological, psychological, and relationship factors are implicated. Psychosexual therapy approaches can be effective in ameliorating the condition, sometimes in conjunction with pharmacological treatment.

Cross-References

- ▶ Cunnilingus
- ▶ Fellatio
- ▶ Female Orgasm and In-Pair Copulation
- ▶ Male Sexual Desire
- ▶ Reactions to Infidelity
- ▶ Victims of Rape

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