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 months[2]
   - 33-38% of women over age 57 report difficulty with orgasm[3]
   - 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 hemodialysis[4]
  - 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 CVA[5]
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 reassurance[6]
   - 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

Therapeutics[7]

1. Acute treatment
    - Patient and partner education (resource: Becoming Orgasmic- see below) may be an adequate intervention for primary anorgasmia[8]
    - 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 studies[10]
        - 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 frequency[13]
        - May improve women's comfort with and awareness of their genitals, and may add to the beneficial effect of increasing sexual fantasies[14]
    - 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
        - Buproprion (330 mg/day) may improve orgasmic response in women with hypoactive sexual desire disorder[15]
            - Limited evidence suggests possible effectiveness in non-depressed women with orgasmic dysfunction (Bupropion-SR 150 mg/day-300 mg/day)[16]
    - Buproprion is often used to counteract SSRI induced sexual dysfunction
    - No studies specific to female orgasmic difficulty[17]

        - Use of sildenafil to improve sexual symptoms in premenopausal women is not supported by evidence[18]
            - Pilot evidence suggests possible benefit for post-menopausal women with orgasmic dysfunction[19]
        - Transdermally delivered testosterone may offer some benefit (libido, arousal, and orgasm) to oophorectomized women already being treated with estrogen[20]
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 treatment[11]
2. Prognosis improved for younger, married, emotionally healthy women[21]

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
    - 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.

References

1. Diagnostic and Statistical manual of Mental Disorders, fourth edition, text revision.(DSM-IV-TR). American Psychiatric Association. Washington, DC. 2000.
2. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: Prevalence and predictors. JAMA 1999; 281(6): 537-544.
3. Lindau ST. Schumm LP, Laumann EO et al. A study of sexuality and health among older adults in the United States. NEngl JM 2007; 357: 762-764.
4. Nappi R, Salonia A, Traish AM, van Lunsen RHW et al. Clinical biologic pathophysiologies of women's sexual dysfunction. Journal of Sexual Medicine 2005; 2:4-25.
5. KorpelainenJT, Kauhanen ML, Kemola H, Malinen U, Myllyla VV. Sexual dysfunction in stroke paitents. Acta Neurol Scand 1998; 98:400-405.
6. Frank JE, Mistretta P, Will J. Diagnosis and treatment of female sexual dysfunction. American Family Physician 2008; 77(5):635-642.
7. Meston CM, Hull E, Levin RJ, Sipski M. Disorders of orgasm in women. J Sex Med. 2004;1(1):66-68.
8. Dodge LJ, Glasgow RE, O'Neil HK. Bibliotherapy in the treatment of female orgasmic dysfunction. Journal of Consulting and Clinical Psychology. 1982; 50: 442-443.
9. Hurlburt DF, Apt CV. The coital alignment technique and directed masturbation: A comparative study on female orgasm. Journal of Sex and Marital Therapy. 1995; 21:21-29.
10. Billups KL, Berman L, Berman J et al A new non-pharmacological vacuum therapy for female sexual dysfunction. J Sex Marital Ther. 2001 Oct-Dec;27(5):435-41.
11. LoPiccolo J, Stock WE. Treatment of sexual dysfunction. Journal of Consulting and Clinical Psychology 1986; 54: 158-167.
12. Morokoff PJ, LoPiccolo J. A comparative evaluation of minimal therapist contact and 15-session treatment for female orgasmic dysfunction. Journal of Consulting and Clinical Psychology, 1986. 54: 294-300.
13. Chambless DL, Sultan FE, Stern TE et al. Effect of pubococcygeal exercises on coital orgasm in women. Journal of Consulting and Clinical Psychology. 1984; 52:114-118.
14. Messe MR, Geer JH (1985). Voluntary vaginal musculature contractions as an enhancer of sexual arousal. Archives of Sexual Behavior. 1985; 14: 13-28.
15. Segraves RT, Clayton A, Croft H, Wolf A, Warnock J. Buproprion sustained release for the treatment of hypoactive sexual desire disorder in premenopausal women. Journal of Clinical Psychopharmacology. 2004; 339-342.
16. Modell JG, May RS, Katholi CR. Effect of bupropion-SR on orgasmic dysfunction in nondepressed subjects: A pilot study. Journal of Sex and Marital Therapy. 2000; 26: 231-240.

17. Taylor MJ, Rudkin L, Hawton K. Strategies for managing antidepressant-induced sexual dysfunction: systematic review of randomized controlled trials. J Affective Disorders 2005; 88: 241-254.
18. Basson R, McInnes RM Smith MD, Hodgson G, Koppiker N. Efficacy and safety of sildenafil citrate in women with sexual dysfunction associated with female sexual arousal disorder. Journal of Women's Health and Gender-based medicine. 2002; 11: 367-377.
19. Cavalcanti AL, Bagnoli VR, Fonseca AM, Pastore RA et al. Effect of sildenafil on clitoral blood flow and sexual response in postmenopausal women with orgasmic dysfunction. International Journal of Gynecology and Obstetrics 2008; 102: 115-119.
20. Davis SR, Guay AT, Shifren JL, Mazer NA. Endocrine aspects of Female Sexual Dysfunction. Journal of Sexual Medicine 2004; 1(1): 82-86.
21. Libman E, Fichten CS, Brender W, Burstein R, Cohen J, Binik YB. A comparison of three therapeutic formats in the treatment of secondary orgasmic dysfunction. Journal of Sex and Marital Therapy. 1984; 10:147-159.
22. Basson R, Althof S, Davis S, Fugl-Meyer K et al. Summary of the recommendations on sexual dysfunctions in women. Journal of Sexual Medicine 2004; 1(1): 24-34.

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

Editor: Chandrika Iyer, MD, *St. John FMRP, Detroit, MI*