

Orgasmic Disorder

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Orgasmic disorder involves orgasm that is absent, markedly diminished in intensity, or markedly delayed in response to stimulation despite high levels of subjective arousal.

Women with orgasmic disorder often have difficulty relinquishing control in nonsexual circumstances. Contextual factors (eg, consistently insufficient foreplay, early ejaculation by the partner, poor communication about sexual preferences), psychologic factors (eg, anxiety, stress, lack of trust in a partner, fear of not being in control), and drugs can contribute to orgasmic disorder (see [Overview of Female Sexual Function and Dysfunction : Etiology](#)). Lack of knowledge about sexual function may also contribute. Damage to genital sensory or autonomic nerves (eg, due to diabetes or multiple sclerosis), vulval dystrophy (eg, lichen sclerosus), or, much more commonly, use of SSRIs may lead to orgasmic disorder.

Treatment

Self-stimulation

Psychologic therapies

Data support encouraging self-stimulation. A vibrator placed on the mons pubis close to the clitoris may help, as may increasing the number and intensity of stimuli (mental, visual, tactile, auditory, written), simultaneously if necessary. Education about sexual function (eg, need to stimulate other areas of the body before the clitoris) may help. Psychologic therapies, including cognitive-behavioral therapy and psychotherapy, may help women identify and manage fear of relinquishing control, fear of vulnerability, or issues of trust with a partner. Recommending the practice of mindfulness and using mindfulness-based cognitive therapy (MBCT—see [Treatment](#)) can help women pay attention to sexual sensations (by staying in the moment) and not judge or monitor these sensations. In women taking an SSRI, symptoms may decrease when bupropion is added. One study supports the use of sildenafil.



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