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Orgasmic Disorder

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Orgasmic disorder is lack of or delay in sexual climax (orgasm) even though sexual stimulation is sufficient and the woman is sexually aroused mentally and emotionally.

Women may not have an orgasm if lovemaking ends too soon, there is not enough foreplay, or they are afraid of losing control or letting go.

Women are encouraged to try self-stimulation (masturbation), and for some women, psychologic therapies are helpful.

The amount and type of stimulation required for orgasm varies greatly from woman to woman. Most women can reach orgasm when the clitoris (which corresponds to the penis in men) is stimulated, but fewer than half of women regularly reach orgasm during sexual intercourse. About 1 of 10 women never reaches orgasm, but many of them nonetheless consider sexual activity to be satisfactory.

Women with orgasmic disorder cannot have an orgasm under any circumstances, even when they masturbate and when they are highly aroused. However, not having an orgasm usually occurs because the woman is not sufficiently aroused and is thus considered an arousal disorder, not an orgasmic disorder. Inability to have an orgasm is considered a disorder only when the lack of orgasm distresses the woman. Lovemaking without orgasm can cause frustration and may result in resentment and occasionally a dislike for anything sexual.

Causes

Situational and psychologic factors can contribute to orgasmic disorder. They include the following:

Lovemaking that consistently ends before the woman is aroused enough (as when the man ejaculates too soon)

Insufficient foreplay

In one or both partners, lack of understanding about how their genital organs function

Poor communication about sex (for example, about what sort of stimulation a person enjoys)

Problems in the relationship, such as unresolved conflicts and lack of trust

Anxiety about sexual performance

Fear of letting go, being vulnerable, and not being in control (possibly as part of a fear of not being in control of all aspects of their life or as part of a general tendency to keep emotions in check)

A physically or emotionally traumatic experience, such as sexual abuse

Psychologic disorders (such as depression)

Physical disorders can also contribute to orgasmic disorder. They include nerve damage (as results from diabetes, spinal cord injuries, or multiple sclerosis) and abnormalities in genital organs.

Certain drugs, particularly selective serotonin reuptake inhibitors (SSRIs, a type of antidepressant—see Table: Drugs Used to Treat Depression), may specifically inhibit orgasm.

Treatment

Doctors may encourage women to learn what type of touch is pleasurable and arousing by trying self-stimulation (masturbation). Other techniques that may help include relaxation techniques and sensate focus exercises. In sensate focus exercises, partners take turns touching each other in pleasurable ways (see Sexual Arousal Disorders : Treatment). Couples may try using more or different stimuli, such as a vibrator, fantasy, or erotic videos. A vibrator may be especially useful when there is nerve damage.

Education about sexual function may help. For some women, incorporating stimulation of the clitoris may be all that is needed.

Psychologic therapies, such as cognitive-behavior therapy and mindfulness-based cognitive therapy (MBCT—see Treatment), may help women identify and manage fear of relinquishing control, fear of vulnerability, or issues of trusting a partner. Psychotherapy may be useful for women who have been sexually abused or have psychologic disorders, as may MBCT. Practicing mindfulness (focusing on what is happening in the moment) can help women pay attention to sexual sensations, without making judgments about or monitoring what is happening.

If an SSRI is the cause, adding bupropion (a different type of antidepressant) may help. Or another antidepressant may be substituted. Some evidence suggests that if women stopped having orgasms when they started taking SSRIs, sildenafil may help them have orgasms again.

Spotlight on Aging

The main reason older women give up on sex is lack of a sexually functional partner. However, age-related changes, particularly those due to menopause, can make women more likely to experience sexual dysfunction. Also, disorders that can interfere with sexual function, such as diabetes, atherosclerosis, urinary tract infections, and arthritis, become more common as women age. However, these changes need not end sexual activity and pleasure, and not all sexual dysfunction in older women is caused by age-related changes.

In older women as in younger women, the most common problem is low sexual desire.

As women age, less estrogen is produced.

- The tissues around the vaginal opening (labia) and the walls of the vagina become less elastic and thinner (a disorder called atrophic vaginitis), This change can cause pain during sexual activity that involves penetration.
- Vaginal secretions are reduced, providing less lubrication during sexual intercourse.
- Less and less testosterone is produced starting when women are in their 30s and stopping by about age 70. Whether this decrease leads to decreased sexual interest and response is unclear.
- The acidity of the vagina decreases, making the genitals more likely to become irritated and infected.
- Lack of estrogen may contribute to age-related weakening of muscles and other supportive tissues in the pelvis, sometimes allowing a pelvic organ (bladder, intestine, uterus, or rectum) to protrude into the vagina. As a result, urine may leak involuntarily, causing embarrassment.
- With aging, blood flow to the vagina is reduced, causing it to become shorter, narrower, and drier. Blood vessel disorders (such as atherosclerosis) can reduce blood flow even more.

Other problems may interfere with sexual function. For example, older women may be distressed by changes in their body caused by disorders, surgery, or aging itself. They may think that sexual desire and fantasy are improper or shameful at an older age. They may be worried about the general health or sexual function of their partner or their own sexual performance. Many older women have sexual desire, but if their partner no longer responds to them, their desire may be slowly extinguished.

Older women should not assume that sexual dysfunction is normal for older age. If sexual dysfunction is bothering them, they should talk to their doctor. In many cases, treating a disorder (including depression), stopping or substituting a drug, learning more about sexual function, or talking to a health care practitioner or counselor can help.

If atrophic vaginitis is a problem, estrogen can be inserted into the vagina as a cream (with a plastic applicator), as a tablet, or in a ring. Estrogen may be taken by mouth or applied in a patch or gel to an arm or a leg but only if menopause occurred recently. Occasionally, testosterone is prescribed in addition to estrogen therapy if all other measures are ineffective, but prescribing this combination is not recommended. It is still considered experimental and long-term safety is unknown.