Female Orgasmic Disorder DSM-5 302.73 (F52.31)

DSM-5 Category: Sexual Dysfunction

Introduction

Female orgasmic disorder is a sexual dysfunction disorder that effects as many as 42% of women at some time during the lifespan. According to the DSM-5, female orgasmic disorder is characterized by a significant change in orgasm such as delay, reduction of intensity or cessation. Although no one cause has been identified, female orgasmic disorder has been associated with relational problems, stress, depression, anxiety, medications and chronic medical conditions. Several treatment options are available to address the complex components of female orgasmic disorder.

Symptoms of Female Orgasmic Disorder

Female orgasmic disorder is marked by a significant change in orgasm. The DSM-5 explains that These changes can be reduced intensity, delay, infrequency or absence of orgasm. The symptom must last for at least six months and not be related to other physical, mental or relational problem. For some women, the problematic change in orgasm occurred after a period of normal sexual activity and enjoyment. For other women, the condition is lifelong as has persisted since her first sexual encounter. In some cases, the disturbance may only happen with some sexual activities or partners but not persist in other situations. For some women, the condition persists in all sexual encounters. Every woman responds to this condition differently. Some women experience high levels of distress, while others are only mildly bothered (American Psychiatric Association, 2013). The presence of distress is necessary for proper diagnosis of female orgasmic disorder. One study found that more than half of married women

report arousal or orgasm problems. Of these, more than three quarters reported they were satisfied with their sexual relationships (Laan, Rellini & Barnes, 2013).

Causes of Female Orgasmic Disorder

Female orgasmic disorder is complex and no single cause has been identified. However, the DSM-5 asserts that several factors may contribute to the disorder. First, partner problems can be related to female orgasmic disorder. A woman whose partner is in poor health or has sexual problems may experience disruption in orgasm. Similarly, relationship problems can contribute. Circumstances within a relationship such as fighting, abuse, poor communication, and misunderstandings or differences regarding sexual intimacy and satisfaction can lead to sexual problems. Stress can also affect sexual desire and orgasm. Women experiencing extreme stress from a variety of life circumstances can experience problems with orgasm. Personal vulnerabilities can also contribute to female orgasmic disorder. These include a personal history of sexual abuse, poor body image, anxiety or depression (American Psychiatric Association, 2013). Psychosocial factors such as attitude about sex, religious views, sexual experience and level of educational also contribute (Laan, Rellini & Barnes, 2013).

Female orgasmic disorder can also be caused by physical conditions, illness or medication (American Psychiatric Association, 2013). Chronic diseases such a heart disease, thyroid problems, asthma, diabetes, multiple sclerosis and pelvic conditions are positively correlated with female orgasmic disorder. Additionally, several medications are associated with sexual dysfunction. Antidepressants, antipsychotics, mood stabilizers, cancer treatments, and cardiovascular drugs inhibit orgasm (Laan, Rellini & Barnes, 2013).

A genetic component is also suspected, as heritability range from 34% for difficulty achieving orgasm during intercourse, to 45% for achieving orgasm through masturbation (Laan, Rellini & Barnes, 2013). However, because many women are unaware of the sexual histories of their family members, this position is controversial. A 2011 Australian study examined the sexual arousal, activity and orgasms of 2,914 adult female twins to measure orgasm rates during a variety of sexual activities. The study found that genetics, as well as several factors including social status, occupation, childhood illness, lifetime number of partners, and age of first sexual experience had no significant impact on female orgasmic disorder (Zietsch, et al., 2011).

Prevalence of Female Orgasmic Disorder

After hypoactive sexual desire disorder, female orgasmic disorder is the most common sexual disorder among women. As many as 28% of women in the United States, South America and Europe meet criteria for female orgasmic disorder. In Asia, prevalence is as high as 46% (Laan, Rellini & Barnes, 2013). In some countries, prevalence is unknown because of the discussion of sexual matters, particularly among women is culturally restricted (Adegunlove, 2011).

Comorbidity

A high level of comorbidity exists between female orgasmic disorder and other sexual dysfunctions. 31% of women diagnosed with female orgasmic disorder also experience difficulties with sexual arousal. Another half of women also experience problems with lubrication, desire, pain or vaginismus. Anxiety is another disorder diagnosed in more than a quarter of women who meet criteria for female orgasmic disorder. A general propensity for anxiety can lead to anxiety related to sexuality and the sexual experience, inhibiting orgasm. Depression is also commonly associated with sexual dysfunction. More than half of women

diagnosed with female orgasmic disorder also meet criteria for depression (Laan, Rellini & Barnes, 2013).

Treatment of Female Orgasmic Disorder

Although female orgasmic disorder is complex, several effective treatment options are available Because relational problems are often present in women diagnosed with female orgasmic disorder, couples therapy is an effective intervention (Laan, Rellini & Barnes, 2013). During couples therapy, the patient along with her partner have an opportunity to strengthen communication skills, listening, reflection, emotional expression and conflict resolution (Pereira, et al. 2013). In cases where the woman is treated individually, cooperation from the sexual partner is recommended. When distressing thoughts and emotions are present in a women diagnosed with female orgasmic disorder, cognitive behavioral therapy can effectively address these concerns to reduce symptoms (Laan, Rellini & Barnes, 2013).

In cases where sexual inexperience or discomfort is involved, direct masturbation training is recommended. This approach typically lasts from 4-16 weeks. During direct masturbation training, patients are gradually exposed to genital stimulation and may incorporate role play, sexual fantasy and vibrators to facilitate orgasm. Direct masturbation training can take place in individual therapy, couples therapy and group therapy. This technique is extremely effective, resulting in 90% of women becoming orgasmic during treatment. For women whose sexual dysfunction stems from inability to focus or remain "in the moment" during sexual activity, yoga practice and mindfulness training are effective interventions. For women whose sexual dysfunction developed during or after menopause, hormonal treatment is often useful in conjunction with behavioral treatments. (Laan, Rellini & Barnes, 2013).

References

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