Female orgasmic disorder: Epidemiology, clinical features, assessment, and diagnosis

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INTRODUCTION

Female orgasmic disorder is characterized by a persistent or recurrent delay, infrequency, or absence of orgasm, or markedly diminished intensity of orgasm, despite adequate sexual stimulation. To diagnose female orgasmic disorder, the symptoms must be present on all or almost all occasions of sexual activity and must cause significant distress [1]. Treatment for female orgasmic disorder consists principally of psychosocial interventions, though clinical trials of their efficacy are limited.

This topic discusses the epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis of female orgasmic disorder. The treatment of female orgasmic disorder; the assessment of patients with sexual dysfunction; the epidemiology, risk factors, evaluation, and an overview of treatment of women with sexual dysfunction; and the prevalence and management of sexual dysfunction due to serotonergic antidepressants are discussed separately. (See "Treatment of female orgasmic disorder" and "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation" and "Overview of sexual dysfunction in females: Management" and "Sexual dysfunction caused by selective serotonin reuptake inhibitors (SSRIs): Management", section on 'Assessment'.)

TERMINOLOGY

Female orgasmic disorder may be lifelong or acquired, generalized (occurring in all situations), or situational (occurring in select situations). An example of the situational type of the disorder is a woman who has orgasms through masturbation but not during partnered sexual activity. Distinctions between "primary" and "secondary" orgasmic disorder are important because of their implications for case conceptualization and clinical management. (See "Treatment of female orgasmic disorder".)

Primary female orgasmic disorder — Women with primary female orgasmic disorder have not previously experienced orgasm in any situation. In the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), "Never experienced an orgasm under any situation" can be specified [1]. Other terms used synonymously include:

- "Lifelong generalized female orgasmic disorder"
- "Primary anorgasmia"
- "Preorgasmic"

Secondary female orgasmic disorder — Women with secondary female orgasmic disorder have previously been orgasmic but present with current orgasmic dysfunction. As examples, this category would include women who were once orgasmic but not any longer (generalized) as well as women who are orgasmic through masturbation but not partnered sexual activity (situational).

Other terms used synonymously include:

- "Situational orgasmic disorder"
- "Acquired orgasmic disorder"

EPIDEMIOLOGY

Epidemiologic studies have found the estimated prevalence of orgasmic dysfunction to vary internationally from approximately 20 to 40 percent. Female orgasmic disorder has a lower prevalence than these estimates, because diagnostic criteria for female orgasmic disorder require that the symptoms are distressing or bothersome to the respondent [2,3]. (See 'Diagnostic criteria' below.)

Surveys conducted in the United States, the United Kingdom, Mexico, and Australia have estimated that 18 to 29 percent of women report problems with attaining orgasm [4-9]. As an

example, a nationally representative survey of over 25,000 adult women in the United States found that approximately 21 percent reported problems with attaining orgasm [10,11].

Only a subgroup of the samples in large epidemiological studies of sexual dysfunction are likely to have met criteria for female orgasmic disorder. Studies that incorporate measurement of orgasmic difficulties and concurrent associated distress can provide more accurate estimates of the prevalence of female orgasmic disorder. As examples, a study of 500 United States women using a more detailed instrument found that only 4.7 percent of respondents endorsed both problems with orgasm and high levels of associated distress [12]. A similarly designed study of 356 Australian women concluded that 8 percent of women endorsed problems with orgasm and concurrent related personal distress [13], a figure that was replicated in another survey of 6986 Australian women between the ages of 18 and 39 [14].

Bisexual females and females who have sex with females are not well represented in epidemiological studies of sexual dysfunction, but smaller studies have found rates of orgasm problems that are consistent with rates in the broader population [5,15].

Risk factors — Demographic risk factors for orgasm problems in the general population include [16-19]:

- Lower educational attainment
- Lower income
- Poorer health status
- Depression and other mental health disorders

Population-based studies do not show a consistent link between age and problems with orgasm.

Country of origin and self-identified ethnicity are not consistently associated with problems with orgasm. Data from a study of 40- to 80-year-old adults in 29 countries found somewhat higher prevalences of problems with orgasm among women in East and Southeast Asian countries [16]. However, in an Australian study of young women (ages 18 to 39), self-identified Asian ethnicity was associated with a lower likelihood of orgasmic dysfunction [14].

Comorbid disorders — There are few rigorous studies of comorbidity of female orgasmic disorder specifically, although several studies have examined associations between subjective difficulty with orgasm and other psychiatric conditions.

Females with depression are two to four times more likely than females without depression to report problems in reaching orgasm [4,20]. This association may be weaker outside the United

States and United Kingdom [16]. In a survey of a nationally representative household survey in the United States, 55 percent of adult women who reported a distressing problem with orgasm also endorsed one or more key symptoms of depression. Similar percentages of depressed women reported problems with low sexual desire and sexual arousal [10], suggesting a generalized effect of depression on sexual function in women.

Clinically significant anxiety symptoms are associated with a twofold risk of problems with orgasm [20]. Obsessive-compulsive disorder may specifically confer risk for problems with orgasm, which may reflect difficulties with sexual expression in general [21].

PATHOGENESIS

The pathogenesis of female orgasmic disorder is best understood in the context of women's normal orgasmic function.

Normal functioning — Physiologic and subjective components of women's orgasm are described separately. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Female sexual response cycle'.)

Women vary in the intensity, type, and duration of stimulation required for orgasm. Most women require some degree of clitoral stimulation to experience orgasm. Indirect stimulation of the clitoris through vaginal intercourse may be sufficient to trigger orgasm in the majority of women, at least part of the time [19], whereas others may respond more readily and reliably to direct clitoral stimulation. Stimulation of other erotically sensitive areas (eg, breast or nipple stimulation) may trigger orgasm as well. Some women with complete spinal cord injury maintain the ability to experience orgasm through vaginal-cervical stimulation, a process that appears to be vagally mediated [22,23]. As examples, orgasms can occur in women during sleep [24,25], and there are isolated reports of women who are able to experience orgasm through fantasy alone [26,27].

Anatomic differences among women may explain some variation in the ease with which women may experience orgasm solely through vaginal intercourse [28-30]. The inability to do so is not a disorder, but rather a typical (and sometimes modifiable) variant of sexual response.

Data from population-based twin studies suggest that heritable factors may account for over 30 percent of variance in orgasmic frequency during intercourse and at least 45 percent of variance in orgasmic frequency with masturbation [31,32].

Psychological and cultural factors — Problems with orgasm in women are multifactorial and may be related to a variety of inhibitory psychosocial factors at the level of the individual, couple, and/or sociocultural context. While some of these factors are modifiable, others may represent more stable traits (eg, a general tendency toward behavioral inhibition such as introversion, or a lower propensity for sexual excitement).

Intrapsychic factors — While early development of treatments for sexual dysfunction were based on the concept of "sexual anxiety" [33,34], the general concept of inhibition may apply more broadly to the understanding of female orgasmic disorder.

The Dual Control Model proposes that a combination of excitatory and inhibitory processes contribute to sexual response [35]. The model posits that individuals vary in their propensity for sexual excitation and inhibition based on a variety of factors including:

- Genetics
- Prior experiences
- Sociocultural context
- Motivational factors

Research suggests that inhibitory factors associated with orgasmic difficulty include worry or negative thoughts about one's own sexual function and the tendency to be easily distracted or interrupted from sexual arousal [36-39]. It is unclear, however, whether these factors cause or are caused by orgasmic dysfunction.

Positive attitudes and representations of sexuality appear to be associated with better orgasmic function and/or a higher frequency of orgasm during sexual activity in women. Evidence suggests that individuals who report being more easily sexually aroused are less likely to experience orgasmic dysfunction [18], whereas those who do not experience erotic thoughts tend to report infrequent orgasm [37]. Surveys provide further evidence supporting the role of positive affect and attitudes on orgasmic function:

- In a national sample of 2049 Finnish women, factors associated with more frequent orgasm included higher ratings of the importance of orgasm and self-perception as a skilled sexual partner [38].

- A survey of 926 heterosexual women found that positive affect during sexual activity predicted more frequent orgasm [37]. Similarly, a survey of 250 women with self-reported orgasm problems and 250 age-matched controls without sexual problems found that women who reported problems with orgasm endorsed more negative and less positive affect during sexual activity compared with controls [39].

Mindfulness — A mental state characterized by nonjudgmental awareness of one's thoughts, feelings, and perceptions – may be associated with better sexual functioning. A study comparing 75 anorgasmic women with 176 women without orgasmic difficulties, the latter group endorsed higher levels of mindfulness during partnered sexual activity and in day-to-day activities [40].

Sexual inhibition contributing to anorgasmia may be a manifestation of personality traits. A population-based study suggested that infrequent coital orgasm is associated with personality traits of introversion, emotional instability, and less openness to new experiences, whereas agreeableness and conscientiousness appear unrelated to orgasmic frequency [19].

Relationship factors — Studies suggest a variety of relationship factors are associated with sexual functioning or related behaviors:

- Members of heterosexual couples with an anorgasmic female partner have been found to exhibit more difficulty communicating about sexual topics [41-43]. In a large survey, ease of sexual communication predicted a higher probability of orgasm during sexual intercourse [38].

- Women who have concerns or doubts about the future of their intimate relationships were more likely to report problems with orgasm [16]. Greater satisfaction with the relationship predicted more frequent orgasm [38] and shorter latency to orgasm during sexual activity [44].

- In shared sexual activities, one partner's sexual function and willingness to engage in foreplay has been found to influence orgasmic function in the other partner [45].

- A nationally representative survey of over 1000 single females in the United States found that self-identified females who have sex with females reported overall higher rates of orgasm with a familiar partner compared with women who identified as heterosexual or bisexual [46].

Sociocultural factors — Sociocultural factors may influence a woman's comfort with sexual expression and experience of orgasm. Cultures vary with respect to their recognition of, and emphasis on, female sexual pleasure; these factors may influence the ease with which women attain orgasm [47]. Sexual guilt and endorsement of common sexual myths are associated with orgasm problems [41]. Pinpointing the origins of negative sexual attitudes and myths, however, is not straightforward. Although certain forms of religious expression influence sexual attitudes [48], religiosity per se does not necessarily hinder orgasmic function.

Medical and medication-related causes — A number of medical conditions can cause sexual dysfunction in females. These are discussed separately. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Medical history' and 'Differential diagnosis' below.)

Acquired orgasmic dysfunction is more commonly due to iatrogenic causes than caused by a medical condition. For example:

- The use of antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs), is commonly associated with delayed orgasm in both men and women. (See "Sexual dysfunction caused by selective serotonin reuptake inhibitors (SSRIs): Management".)

- Antipsychotic drugs are associated with orgasmic dysfunction, particularly first-generation neuroleptics [49]. These effects may be due to antidopaminergic properties and induced hyperprolactinemia. Second-generation antipsychotics appear less likely to cause these side effects [50-52]. A meta-analysis found orgasmic dysfunction to be reported in fewer than 10 percent of women taking quetiapine or aripiprazole, compared to more than 20 percent of women receiving haloperidol [53]. (See "Second-generation antipsychotic medications: Pharmacology, administration, and side effects", section on 'Sexual side effects' and "First-generation antipsychotic medications: Pharmacology, administration, and comparative side effects", section on 'Sexual dysfunction'.)

- A short-term decrement in orgasmic function may follow pelvic surgery or vaginal childbirth. Long-term orgasmic capacity is usually unaffected by routine pelvic surgeries, including simple hysterectomy [54,55]. More radical pelvic surgeries and pelvic radiotherapy have greater potential to disrupt orgasmic functioning for a longer period of time compared to routine pelvic surgeries. As an example, long-term survivors of vaginal and cervical cancers report orgasmic problems at about twice the rate of women in the general population [56]. Women who have undergone cancer treatment are also more likely to have problems with sexual desire, arousal, and pain [57].

Acute intoxication with central nervous system depressants such as alcohol [58] may inhibit orgasmic response. Substance use that can cause sexual dysfunction in woman is discussed in detail separately. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Substance use'.)

CLINICAL FEATURES

Although female orgasmic disorder may manifest as a complete absence of orgasm, some women with acquired female orgasmic disorder report delayed orgasm (ie, requiring longer and/or more intense stimulation to reach orgasm) or a less intense experience of orgasm. Women may also report a sense of impending orgasm that does not reach a peak or resolution despite continued stimulation, sometimes resulting in a feeling of sexual frustration or unresolved genital tension.

Orgasmic dysfunction caused by medical illness or drug treatment is usually experienced globally, that is, in both partnered and masturbatory activity, whereas acquired situational female orgasmic disorder is more likely to manifest only in partnered sexual activity.

Inaccurate expectations of orgasm in an individual who does not recognize an intact response may at times be described as a lifelong orgasmic dysfunction.

COURSE

The natural history of female orgasmic disorder is heterogeneous due to variation in its etiology. Studies have not been consistent in the methods used to measure the duration of orgasmic dysfunction, but some data are available [59]:

- 3.7 percent of women in a large United Kingdom sample reported inability to orgasm lasting six months or longer
- 14.4 percent reported an orgasm problem lasting one month or longer

In young women and in women with limited sexual experience, the course of lifelong, global female orgasmic disorder is difficult to distinguish from normal sexual development. A period of sustained sexual activity is generally necessary in order to establish whether the problem is persistent or recurrent, although a pattern of orgasm difficulty with masturbation could meet this criterion. Once manifest, the disorder is likely to persist if precipitating factors (eg, stress, relationship conflict, medication use) do not resolve.

ASSESSMENT

Assessment and diagnosis of female orgasmic disorder is based on self-reported symptoms, usually during the course of a clinical interview. The aspects of the individual's history that should be included in the clinical interview are discussed below.

Quality, course, and associated symptoms — We address the following in assessing the symptoms of female orgasmic disorder:

- A general description of how the problem is experienced (eg, delayed, absent, and/or weak orgasm).
- The onset, duration, and frequency (ie, the proportion of sexual encounters in which there is a problem with orgasm) of symptoms, including any change over time – The clinician should assess whether the patient's symptoms have been lifelong or acquired. Women with primary anorgasmia may express uncertainty about what orgasm feels like. When acquired female orgasmic disorder is suspected, it is important to compare feelings of arousal to the previous state of functioning.
- Intensity of arousal – It can be difficult to describe or assess the intensity of arousal. Asking the woman to what extent she feels "excited" or "turned on" during sexual encounters can help establish her subjective perception of sexual arousal. It can be helpful for the clinician to inquire about the patient's experience of physical indicators of sexual arousal during sexual stimulation, such as genital warmth, tension, pulsing, and lubrication. If the woman appears to experience little or no sexual arousal with most sexual encounters, the diagnoses of female sexual arousal disorder and/or hypoactive sexual desire disorder should be considered.
- Situational specificity of the problem (ie, whether the problem is global or specific to certain sexual activities, partners, or other situational factors).
    - Presence or absence of difficulties with orgasm during masturbation – It is common for women to report experiencing orgasm through self-stimulation but not during partnered sexual activity. This alone does not necessarily establish the presence of situational female orgasmic disorder, since partnered sexual activity may not be sufficiently arousing or the problem may not be sufficient to cause distress in this context.
    - If orgasm problems are limited to one particular partner but not past partners, careful assessment may reveal interpersonal problems or concerns about the pattern of sexual activity in the relationship. Alternatively, the partner may lack sexual knowledge and skills. The clinician should be sensitive to the possibility that a patient may find it less threatening to take on the label of "dysfunctional" than to describe problems with the partner or the relationship.

- Assessment needs to determine whether the woman is anorgasmic despite the presence of adequate sexual stimulation. This requires careful history taking and appraisal of contextual factors that might influence sexual response. The absence of an orgasm is an expected consequence of a sexual encounter that lacks psychological and physical stimulation.

- Anxiety or inhibition related to sexuality – This can be assessed by inquiring about the frequency of self-monitoring during sexual activity, the woman's level of comfort in discussing sexual topics with her partner, and her perception of her own body, especially her genitals. Observing the woman's speech and behavior (eg, marked avoidance of language referring to genitals or sexual behaviors) may also provide evidence of general discomfort with sexuality. Further assessment may include queries about sexual mores and values in the woman's family of origin, which may reveal negative attitudes or a lack of knowledge about sexuality.

Impact of the symptoms — Female orgasmic disorder should only be diagnosed in women who experience marked distress or interpersonal difficulty due to absent or delayed orgasm. It is important to inquire about the impact of the problem on the woman's life and the nature of her concern. Most women seeking treatment for a sexual problem are significantly distressed. In some cases, the woman may not be distressed by the absence of orgasm itself, but by it causing her to worry about whether she is "normal."

The woman's partner may look upon her lack of orgasm as a reflection of their own desirability or competence as a lover. In these instances, a diagnosis is not necessarily appropriate, particularly if the woman does not otherwise perceive her response as problematic. In this case, the issues should be reframed as an opportunity to educate the woman and her partner about typical variations in sexual response.

Corroborative history — Interviewing the couple jointly can yield valuable data about how the partners communicate, solve problems together, and show affection. Presence of conflict, distrust or instability may affect sexual response and function.

The woman should ideally be interviewed alone at some point during the assessment so that private thoughts and feelings can be shared candidly. As an example, the woman may feel uncomfortable talking about her lack of sexual knowledge in the presence of her partner, or she may have difficulty voicing her sexual frustrations and wishes. Some material may be "taboo" within the couple; for instance, a woman who fantasizes about another person to achieve orgasm is unlikely to admit this in the presence of her partner.

How best to handle such private information should be agreed upon by all parties at the beginning of the assessment.

Medical and other associated history — A comprehensive assessment of female orgasmic disorder should include:

- Prior negative experiences of sexuality.
- Prior treatment experiences.
- Symptoms of other psychiatric disorders. (See 'Comorbid disorders' above.)
- Medical history including current use of medications – A medical work-up may be useful if the patient experiences a relatively sudden, generalized, and persistent loss of orgasmic response in the absence of other obvious causal factors. A physical examination can also rule out causes of genital discomfort or dyspareunia that contribute to sexual difficulties. The medical evaluation of women with sexual dysfunction is discussed separately. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Diagnostic evaluation' and 'Comorbid disorders' above and 'Differential diagnosis' below.)

Quantitative measurements and rating scales — Although validated self-report questionnaires are not sufficient to establish a diagnosis of female orgasmic disorder, they can help establish the frequency and severity of symptoms and can be used to monitor treatment response over time. It is generally helpful to assess multiple domains of sexual function to understand how different sexual problems (such as low sexual arousal or sexual pain) may contribute to difficulties with orgasm.

For assessment of patients with female orgasmic disorder, we favor use of the Female Sexual Function Index (FSFI) [60], a brief, clinically feasible, and psychometrically robust measure. The FSFI consists of 19 items covering six domains of functioning, including a three-item orgasmic function domain. Scores can be generated for individual domains and for overall sexual function. In previous research, domain and total FSFI scores discriminated reliably between women with and without sexual problems, including female orgasmic disorder [61-63]. For women involved in a long-term relationship with a sexual partner, assessment of general functioning within the intimate relationship can be collected self-report measures such as the Dyadic Adjustment Scale [64,65], which has been validated in both opposite-sex and same-sex couples and used in a number of studies of sexual function [66].

Measures of genital sensory function, such as tactile, vibratory, and temperature perception thresholds, appear to show some correlation with orgasmic function [67]. Clitoral sensitivity might influence propensity for problems with orgasm. One study found that clitoral, but not vaginal, vibratory sensation thresholds were significantly higher in a sample of 90 women with primary complaint of orgasmic dysfunction as compared to a control group of 110 women without orgasmic difficulties [68]. However, quantitative sensory measures lack sufficient sensitivity and specificity for use in detecting problems with orgasm in the general population [69].

DIAGNOSIS

Diagnostic criteria — The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) criteria for female orgasmic disorder are as follows [1]:

- A. Presence of either of the following symptoms and experienced on almost all or all (approximately 75 to 100 percent) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
  - 1. Marked delay in, marked infrequency of, or absence of orgasm.
  - 2. Markedly reduced intensity of orgasmic sensations.
- B. The symptoms in Criterion A have persisted for a minimum duration of approximately six months.
- C. The symptoms in Criterion A cause clinically significant distress in the individual.
- D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as consequence of severe relationship distress (eg, partner violence) or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Subtypes

- Specify whether lifelong or acquired
  - Lifelong – The disturbance has been present since the individual became sexually active.
  - Acquired – The disturbance began after a period of relatively normal sexual function.

- Specify whether generalized or situational
  - Generalized – Not limited to certain types of stimulation, situations, or partners.
  - Situational – Only occurs with certain types of stimulation, situations, or partners.
- Specify if – Never experienced an orgasm under any situation
- Specify current severity
  - Mild – Evidence of mild distress over the symptoms in Criterion A.
  - Moderate – Evidence of moderate distress over the symptoms in Criterion A.
  - Severe – Evidence of severe or extreme distress over the symptoms in Criterion A.

Differential diagnosis — The differential diagnosis of female orgasmic disorder includes medical and substance-induced conditions, iatrogenic causes, and other mental disorders.

Medical conditions — A number of medical conditions can cause sexual dysfunction in women. These are discussed separately. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Medical history'.)

Substance-induced conditions — Acute intoxication with central nervous system depressants such as alcohol [58] may inhibit orgasmic response. Substance use that can cause sexual dysfunction in woman is discussed in detail separately. (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Substance use'.)

Iatrogenic causes — Acquired orgasmic dysfunction is more commonly due to iatrogenic causes than caused by a medical condition. (See 'Medical and medication-related causes' above.)

Other mental disorders — Problems with orgasm are not a typical symptom of other mental disorders but may accompany manifestations of mood disturbance or anxiety. As an example, a diagnosis of depression is associated with a loss of interest in sex, which may lead to secondary orgasmic dysfunction. Population-based studies have found that depression is a risk factor for orgasm problems in women [16], although it is unclear whether this reflects the widespread use of antidepressant medication. Anxiety that distracts the woman from attending to sexual stimulation (eg, uncontrollable worry) or creates psychological discomfort with sexual stimulation (eg, contamination fears) may also contribute to problems with orgasm.

(See 'Comorbid disorders' above.)

SUMMARY

- **Female orgasmic disorder** – Female orgasmic disorder is characterized by a persistent or recurrent delay, infrequency, or absence of orgasm, or marked reduction in the intensity of orgasm, with the symptoms causing marked distress or interpersonal difficulty. Female orgasmic disorder may be lifelong or acquired, generalized, or situational. (See 'Introduction' above and 'Terminology' above.)

- **Epidemiology** – Epidemiologic studies have found the estimated prevalence of problems with orgasm to vary internationally from 20 to 40 percent; however, the prevalence of female orgasmic disorder is lower than these estimates, because diagnostic criteria for female orgasmic disorder require that the symptoms are distressing or bothersome to the respondent. (See 'Epidemiology' above.)

- **Comorbid disorders** – Limited data suggest possible associations between subjective difficulty with orgasm and other psychiatric conditions such as depression and anxiety disorders. (See 'Comorbid disorders' above.)

- **Pathogenesis** – Problems with orgasm in females are multifactorial and may be related to a variety of inhibitory psychosocial factors at the level of the individual, couple, and/or sociocultural context. Other underlying causes include medical related, medication related, substance use related. (See 'Psychological and cultural factors' above and 'Medical and medication-related causes' above.)

- **Clinical features** – Although female orgasmic disorder may manifest as a complete absence of orgasm, some women with acquired female orgasmic disorder report delayed orgasm (ie, requiring longer and/or more intense stimulation to reach orgasm) or a less intense experience of orgasm. Women may also report a sense of impending orgasm that does not reach a peak or resolution despite continued stimulation. (See 'Clinical features' above.)

- **Assessment** – Assessment and diagnosis of female orgasmic disorder is based on self-reported symptoms, usually during the course of a clinical interview. Careful history of quality, course, duration, situational specificity, and impact of symptoms are essential components of the assessment of female orgasmic disorder. (See 'Assessment' above.)

- **Differential diagnosis** – The differential diagnosis of female orgasmic disorder includes medical and substance-induced conditions (such as multiple sclerosis and alcohol intoxication), iatrogenic causes (including serotonergic antidepressants and pelvic

surgery), and other mental disorders (such as major depression). (See 'Differential diagnosis' above.)

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