Treatment of female orgasmic disorder

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INTRODUCTION

Female orgasmic disorder is characterized by a persistent or recurrent delay in or absence of orgasm following sexual arousal and adequate sexual stimulation. To diagnose female orgasmic disorder, the symptoms must cause marked distress or interpersonal difficulty [1].

Treatment for female orgasmic disorder consists principally of education and psychosocial interventions; clinical trials of their efficacy are limited. No medications have shown convincing evidence of efficacy for the disorder in clinical trials.

This topic discusses the treatment of female orgasmic disorder. The epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis of female orgasmic disorder are discussed separately. Topics related to sexual dysfunction including assessment, epidemiology, treatment, and management of sexual dysfunction due to serotonergic antidepressants are discussed separately.

- (See "Female orgasmic disorder: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation".)
- (See "Overview of sexual dysfunction in females: Management".)
- (See "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.

Primary female orgasmic disorder — Patients with primary female orgasmic disorder have not previously experienced orgasm in any situation. Other terms used synonymously include:

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

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

Other terms used synonymously include:

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

APPROACH TO TREATMENT

Only psychosocial interventions are options for treatment of female orgasmic disorder. No medications have shown convincing evidence of efficacy for the disorder in clinical trials. (See 'Medication' below.)

Selection of treatment for female orgasmic disorder is based on:

- The presumed etiology for a given patient
- Features of the patient's presentation (eg, in what situations does dysfunction occur?)
- Anticipated difficulties with acceptance or adherence to treatment

Our suggestions for psychosocial treatment are largely based on our clinical experience and supported in some cases by small clinical trials of limited methodological quality (see

'Psychosocial interventions' below). A substantial proportion of trials fail to differentiate participants with female orgasmic disorder from those with other sexual disorders. Larger randomized trials and head-to-head comparisons of interventions are needed to guide choices among treatments.

Patient education should be provided to patients with female orgasmic disorder, preceding and supporting a discussion about treatment options. Detailed information about anatomy and sexual function can correct misconceptions that may be contributing to a problem. (See 'Patient education' below.)

For most patients with primary female orgasmic disorder, we suggest treatment with directed masturbation as a first-line therapy over other interventions. Clinical trials have shown directed masturbation to be more efficacious compared with control conditions or other active interventions in helping females with the disorder to achieve orgasm. (See 'Directed masturbation' below.)

As an example, a randomized trial compared a 12-session directed masturbation intervention with a 12-session treatment that included psychoeducation and sensate focus exercises in 37 patients with primary female orgasmic disorder and their male partners [2]. At the end of treatment, more females in the directed masturbation group were able to experience orgasm compared with the education/sensate focus group (90 versus 53 percent). At one year, the females in the directed masturbation group maintained treatment gains.

Treatment of the couple with cognitive-behavioral sex therapy can be helpful in cases that do not respond adequately to education or directed masturbation alone. The clinician should provide education to both partners and incorporate components tailored to contributing factors specific to the couple. (See 'Cognitive-behavioral sex therapy' below.)

- Careful attention should be paid to interpersonal conflicts that appear to contribute to female orgasmic disorder or reduces motivation to resolve it. Orgasmic problems associated with relationship difficulties extending beyond sexual issues can be addressed by couple therapy and or partner communication training. These components can be useful prior to sex therapy or as an integrated intervention. (See 'Potential components' below.)

- For patients with primary female orgasmic disorder in which distorted negative beliefs contribute to orgasm problems, we favor augmentation with more explicit cognitive therapy strategies. (See 'Potential components' below.)

- If primary female orgasmic disorder is accompanied by anxiety that contributes to avoidance of partnered sexual activity and the condition does not respond to education or directed masturbation alone, we favor augmentation with sensate focus exercises. If this combination is not effective, we favor augmentation with exposure therapy. (See 'Sensate focus exercises' below and 'Exposure' below.)

Acquired female orgasmic disorder generally requires treatment directed at the apparent etiology of the dysfunction or contributing factors. When female orgasmic disorder is suspected to be neurogenic in origin, we suggest incorporating use of a dilator or clitoral vacuum suction device to enhance genital stimulation and blood flow.

GENERAL PRINCIPLES

General principles in the management of female orgasmic disorder include:

- Establishing a collaborative relationship with the patient.
- Gathering an adequate psychosexual history to establish probable causal or contributing factors.
- Setting clear, feasible treatment goals. A common pitfall in treatment is to focus chiefly on the attainment of orgasm. Although collaborative goal setting is essential, the patient should be encouraged to focus on facilitators of orgasm (eg, enhancing arousal and pleasurable sensations) and reduce factors that inhibit arousal.
- Ensuring that the patient's mood and psychosocial functioning are stable. Although the patient may prioritize concerns with sexual functioning, problems such as serious mood disturbance, psychotic symptoms, suicidality, and pervasive relational conflict should be treated prior to focusing clinical attention on female orgasmic disorder.
- The nature of most treatments necessitate that patients complete assigned readings, exercises, or activities between clinician visits. Adherence to treatment recommendations, in our experience, contributes to positive outcomes. Clinicians should help patients maintain motivation and resolve barriers to adherence [3,4].

PATIENT EDUCATION

Patient education should precede and support a discussion of treatment options. Females typically welcome accurate, detailed information about anatomy and sexual function. The

process of educating the patient will at times reveal assumptions or misconceptions that may be contributing to a problem. Receipt of corrective information is often therapeutic. Further assessment of contributing factors (eg, relationship problems, negative beliefs about sexuality) can often be conducted during education. The patient should understand the rationale for the proposed treatment and the necessity of her taking an active role in treatment. Motivated, high functioning patients may benefit from an accurate self-help book with little or no additional intervention by the clinician [5]. An excellent resource is the self-help manual "Becoming Orgasmic" [6].

The clinician should have a frank discussion with the patient about the adequacy of stimulation that she receives. Females and their partners may benefit from information about sexual positions and techniques to enhance the woman's sexual stimulation. If the woman engages in vaginal intercourse with a male partner, use of the coital alignment technique has been shown to facilitate orgasm and satisfaction with sexual activity. The coital alignment technique is a variant of the missionary position in which the male partner positions himself higher in relation to the female's body and uses a downward (rather than horizontal) thrusting motion, allowing the base and dorsal side of the penis to come into closer contact with the clitoris. This allows for greater clitoral stimulation and, hypothetically, a greater likelihood of orgasm stimulated through vaginal intercourse [7-9].

Attainment of orgasm through vaginal intercourse may not be an achievable goal in some patients. Clinicians should discuss manual and oral stimulation as normal, legitimate means of attaining orgasm during partnered sexual activity.

Some females will benefit substantially from a single encounter that involves validation, education, and an opportunity to ask questions. However, in our experience, many females present for treatment after multiple failed attempts to remedy the problem on their own and require further treatment.

PSYCHOSOCIAL INTERVENTIONS

Studies of psychosocial interventions, also referred to as "sex therapy techniques," make up the vast majority of the empirical literature on treatments for female orgasmic disorder. Most of the interventions that have been examined empirically are grounded in behavior therapy principles, with considerable overlap among the approaches. They share an emphasis on exposure to novel experiences and information, learning new skills, and generalization of these skills to a range of sexual activities. In clinical practice, these interventions are frequently combined or

coupled with other treatments (eg, marital therapy) for females with more complex presentations, or if monotherapy is not successful.

Clinical trials of these interventions are limited, with small sample sizes and few head-to-head comparisons. In our experience, patients with primary female orgasmic disorder can often be effectively treated with psychosocial interventions [10]. Patients with acquired or situational female orgasmic disorder are less likely to benefit from sex therapy, especially in the long term. (See "Female orgasmic disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Differential diagnosis' and "Overview of sexual dysfunction in females: Epidemiology, risk factors, and evaluation", section on 'Diagnostic evaluation'.)

Psychosocial interventions are described below, followed by data on their efficacy. Where available, data from trials in primary female orgasmic disorder are described first, followed by data in secondary female orgasmic disorder, and then by data in samples including both disorders.

Directed masturbation — Directed masturbation (sometimes referred to as masturbation training) is a program of education and self-awareness exercises aimed at teaching a woman to reach orgasm through self-stimulation and, eventually, through partnered sexual activity [11,12]. After the rationale has been explained and the woman is educated about basic sexual anatomy and physiology, she is instructed to explore her body visually and through touch in a series of exercises at home.

The initial goal is simply to become familiar with one's own body, particularly the genitals. In later steps the focus is to identify areas that are pleasurable to touch, and then to stimulate those areas directly. Erotic videos, pictures, or text, and/or a vibrator can be used to enhance this experience. Once a woman is able to reach orgasm reliably, the partner (if applicable) is brought into the home "practice" sessions so that they can learn to stimulate the woman to orgasm during sexual activity.

Clinicians teach directed masturbation in individual, group, and couples formats [13-15]. The techniques can also be learned in a self-help format (eg, with the manual "Becoming Orgasmic") [5].

Based on our clinical experience, weekly sessions on directed masturbation over a period of five to six weeks are likely to be acceptable and efficacious for most patients, even though clinical trials often studied twice weekly sessions over this period, or weekly sessions over a longer duration [15]. Highly motivated patients may be able to benefit with less frequent contact (eg, semi-monthly sessions), particularly after the first several weeks of treatment.

Efficacy — Multiple small randomized trials found that directed masturbation led to superior outcomes compared with other psychosocial interventions or control conditions in patients with primary female orgasmic disorder [2,5,14,16]. (See 'Psychosocial interventions' above.)

As an example, 63 patients with primary female orgasmic disorder were randomly assigned to one of two self-administered directed masturbation treatments or a waitlist control condition [5]. Treatment groups were split between those who received instructions in writing or in a series of videotapes. Participants in both directed masturbation groups were provided a vibrator. A greater proportion of females assigned to one of the directed masturbation groups experienced orgasm by the end of treatment compared with females in the control group (60 versus 0 percent). There were no differences in outcomes between written and video treatment groups.

Sensate focus exercises — Sensate focus is a couples-oriented treatment that consists of clinician visits for education and treatment planning, and a series of home exercises to increase the partners' comfort with sexual intimacy and reduce avoidance of feared experiences. One goal of sensate focus is to orient the partners' goals for sex toward attaining sensual pleasure rather than orgasm [17].

Sensate focus exercises usually begin by having partners exchange pleasurable touch of areas of the body other than the genitals and breasts, perhaps even while clothed. Subsequent sessions gradually allow for greater touching of breasts, buttocks, and eventually genitals, although intercourse is not recommended until the final stages of treatment.

The therapist typically helps the couple enhance verbal and nonverbal sexual communication skills so that the partners can be enabled to give guidance and feedback to one another regarding their preferences for touch. Barriers to regular, open sexual expression (eg, repeatedly "forgetting" to complete exercises, negative feelings arising during exercises) are also commonly addressed in treatment.

Sensate focus training is typically provided in 10 to 16 sessions, occurring weekly or biweekly.

Efficacy — A single, small randomized trial found sensate focus exercises less effective than directed masturbation in primary female orgasmic disorder [2]. The trial compared a 12-session treatment that included psychoeducation and sensate focus exercises with a directed masturbation intervention in 37 females and their male partners. A smaller proportion of females in the education/sensate focus group compared with the directed masturbation group were able to experience orgasm at the end of the trial (53 versus 90 percent).

Small clinical trials of a sensate focus intervention in females with secondary orgasmic disorder found mixed evidence for improving orgasmic function [18,19]. Improvement was seen in secondary outcomes, including relationship satisfaction and enjoyment of noncoital sexual activity.

As an example, a trial randomly assigned 48 females with secondary orgasmic disorder and their partners to either a waitlist control condition or to one of three 12-session treatments: sensate focus, systematic desensitization, or combined systematic desensitization and sensate focus [18]. Outcomes were reported in terms of a score on a measure of "sexual motivation"; data on orgasmic frequency before and after treatment were not provided. Outcomes for the two monotherapy groups were comparable and superior compared with the control condition, in which no improvement was observed. Combined treatment was found to be inferior to monotherapy. Gains in the sensate focus group were not maintained at six-month follow-up.

Exposure — Exposure therapy may be used as a component of multimodal cognitive-behavioral therapy for female orgasmic disorder to treat anxiety leading to avoidance of sexual activity. Graded exposure to anxiety-provoking stimuli aims to increase the patient's comfort with and reduce avoidance of feared experiences [20]. Techniques such as directed masturbation and sensate focus intrinsically provide graded exposure and often are sufficient to address common sources of anxiety and behavioral inhibition in female orgasmic disorder. However, formal exposure techniques can be incorporated to target anxiety and avoidance around specific situations (eg, being seen in the nude) that are relevant to the patient's goals.

Whereas early treatment protocols emphasized use of relaxation techniques during exposures (systematic desensitization), modern exposure therapy approaches do not emphasize concomitant relaxation [21].

Cognitive-behavioral sex therapy — Cognitive-behavioral sex therapy is a multicomponent intervention that uses behavioral and cognitive techniques selectively, tailored to the identified needs of each couple. Multiple components can be incorporated effectively to treat factors giving rise to female orgasmic disorder.

Potential components

- **Directed masturbation** – (See 'Directed masturbation' above.)
- **Sensate focus exercises** – (See 'Sensate focus exercises' above.)
- **Exposure therapy** – (See 'Exposure' above.)

- **Cognitive therapy** – Therapeutic activities aimed at changing maladaptive thoughts may include cognitive restructuring (systematically identifying and correcting unfounded assumptions that maintain dysfunctional beliefs) and behavioral experiments in which the patient "tests" her beliefs, usually in the context of real-life situations.

  As an example in female orgasmic disorder, a woman who is accustomed to using fantasy during masturbation may avoid fantasy during sexual activity with a new partner due to the belief that it will lead her to desire her partner less. Once given "permission" to engage in fantasy to reach orgasm during sex, she may find that she more often looks forward to lovemaking and may even experience orgasm without the use of fantasy in the future. Other examples of beliefs and assumptions that are addressed include:

  - Fear of experiencing orgasm in front of a partner (eg, difficulty in acting spontaneously out of concern for losing control or having her behavior perceived negatively during orgasm).
  - Unrealistic expectations for sexual performance.
  - Excessive concern about appearance and attractiveness during sexual activity.

- **Couples therapy** – Orgasmic problems associated with relationship difficulties extending beyond sexual issues can be addressed with couples therapy.

- **Partner communication training** – By improving communication in a couple, partner communication training can help modify thoughts and behaviors that contributing to orgasmic problems.

- **Mindfulness training** – Mindfulness training may facilitate heightened awareness of arousal and pleasure and reduce susceptibility to distracting thoughts that inhibit arousal and orgasm.

Efficacy — Contemporary cognitive-behavioral sex therapy has not been studied in randomized trials specific to females with orgasmic disorder. Three small uncontrolled trials in couples with mixed sexual dysfunction found improvement in orgasmic functioning following treatment with differing configurations of cognitive-behavioral sex therapy techniques.

- Twelve females with primary anorgasmia and their partners, taking part in a larger trial, received a 20-session intervention employing cognitive-behavioral therapy strategies [22]. Treatment focused on education, anxiety reduction, communication and assertiveness training, correction of maladaptive beliefs, and, in some cases, masturbation training. In the period following treatment, 22 percent were able to have an orgasm in at least 50

percent of partnered sexual encounters. No subjects met this criterion in a follow-up assessment several months later.

- Thirty-five females with primary or secondary orgasmic disorder and their spouses participated in a larger uncontrolled trial of cognitive-behavioral sex therapy for persons with mixed sexual disorders. The patients were treated with cognitive-behavioral therapy techniques weekly for 15 weeks [23]. Females with primary orgasmic disorder reported increased frequency of orgasm with masturbation posttreatment (from 0 to 25 percent of the time) and more so at three-month follow-up (50 percent of the time); however, these gains did not apply to orgasm with other forms of stimulation. Females with secondary orgasmic disorder reported increased frequency of orgasm during four of five sexual activities assessed, including masturbation and noncoital sexual activity.

- A small randomized trial examined exposure-based treatment (systematic desensitization) as a monotherapy in patients with secondary female orgasmic disorder and their partners. Couples were randomized to either a waitlist control condition or to one of three 12-session treatments: sensate focus, systematic desensitization, or combined systematic desensitization and sensate focus intervention [18]. Outcomes were reported in terms of a sexual motivation score before and after treatment. Sexual motivation improved comparably for the two monotherapy groups; both were superior to the control condition, in which no improvement was observed. Combined therapy was found to be inferior to monotherapy. Gains were maintained in the systematic desensitization group at six-month follow-up.

Other psychosocial interventions — Other treatments that have been tested in female orgasmic disorder include integrative psychosocial treatments that combine treatment modalities drawing on multiple theoretical perspectives [24,25].

As an example, a trial of 26 patients with female orgasmic disorder compared an integrative treatment that included behavioral, psychoanalytic, and hypnosis components, delivered three times per week for 42 weeks, to a 16-week behavioral intervention [17], with a control condition [24]. Immediately following their respective treatments, a greater proportion of females receiving the integrative intervention achieved the desired outcome criterion of achieving orgasm during at least 60 percent of occasions of foreplay or intercourse compared with females in the behavioral group or the control group (88 versus 25 versus percent).

In another trial, 65 sexually active females were randomly assigned to either mindfulness-based cognitive therapy (cognitive therapy incorporating mindfulness training and encouraging the practice of mindfulness throughout prescribed exercises) or cognitive-behavioral therapy. In

each group, therapy was administered in seven video sessions delivered by email and included education on sexuality and behavioral exercises [26]. Although the trial did not select for females with orgasmic dysfunction per se, it was advertised as a study of treatment "to facilitate the reach of orgasm." Both groups experienced statistically significant improvement in sexual function pre- to postintervention as measured by the Female Sexual Function Index Total score and Orgasm subscale score. There was no evidence that the addition of mindfulness training enhanced the effect of the intervention on orgasmic function.

Administration — Administration of psychosocial interventions for female orgasmic disorder requires specialized training beyond that generally received by most types of mental health clinicians. Several professional organizations have membership directories that can be used to locate a specialist in sexual disorders:

- Society for Sex Therapy and Research
- American Association of Sexuality Educators, Counselors, and Therapists
- International Society for the Study of Women's Sexual Health

MEDICATION

Few clinical trials have tested medication for female orgasmic disorder. No medication or dietary supplement has shown sufficient evidence of efficacy to support routine use in treatment of the disorder. Medications tested include:

- *Elaeagnus angustifolia*, a commonly-used plant-derived extract with immunomodulatory properties, has been tested in combination with sildenafil, a phosphodiesterase type 5 inhibitor indicated for treatment of erectile disorder, in females with orgasmic dysfunction [27]. A 2015 trial randomly assigned 125 females with a Female Sexual Function Index (FSFI) score ≤28, indicating dysfunction, to receive one of three interventions:
  - 4.5 grams *E. angustifolia* extract twice daily for 35 days
  - Pill placebo twice daily for 35 days
  - 50 milligrams sildenafil administered one hour prior to sexual activity during a four-week period

  Over the course of the trial, greater improvements in orgasmic function (as measured by the FSFI Orgasm subscale) were observed in patients receiving sildenafil and *E. angustifolia* compared with placebo (a mean improvement of 0.72 and 0.67 versus 0.05 points);

however, the difference in improvement was not clinically meaningful, and the trial had multiple methodologic limitations.

- Oxytocin, a peptide hormone better known for its effects on uterine contractions, milk letdown, and maternal behavior, has also been considered a candidate for pharmacotherapy of female orgasmic disorder. Endogenous oxytocin concentrations in plasma are known to increase with orgasm in males and females [28]. (See "Oxytocin: Drug information".)

  A 2018 randomized crossover trial in 27 healthy, sexually-active females compared intranasal oxytocin with placebo on sexual function parameters, including orgasm quality, immediately following an episode of sexual stimulation [29]. No effect of oxytocin was seen on self-reported ability to reach orgasm, satisfaction from orgasm, or orgasmic intensity. Participants were not selected for sexual problems.

- Topical vasodilators have been tested in trials of woman with orgasmic dysfunction, although more commonly in females with other sexual complaints. A topical cream containing three vasodilators – 2% theophylline, 0.3% isosorbide dinitrate, and 0.065% co-dergocrine mesylate – was compared with a placebo cream in a four-week randomized trial of 60 females with "orgasmic and/or arousal disorders" [30]. Scores on the FSFI Orgasm subscale increased (>1.5 points in both premenopausal and postmenopausal females) from baseline to posttreatment in the vasodilator group but not in participants who received placebo. Between-group analyses were not reported.

OTHER INTERVENTIONS

Pelvic floor exercises — Pelvic floor (Kegel) exercises are used to strengthen the pubococcygeal muscles [31]. Small randomized trials of pelvic floor exercises in patients with female orgasmic disorder did not find them to enhance orgasm [32,33]. A trial reported improved sexual functioning after pelvic floor exercise training in females who were not selected on the basis of sexual disorders [34].

The use of pelvic floor muscle training postpartum for incontinence and in females with pelvic organ prolapse are discussed separately. (See "Effect of pregnancy and childbirth on urinary incontinence and pelvic organ prolapse" and "Posterior vaginal defects (eg, rectocele): Clinical manifestations, diagnosis, and nonsurgical management", section on 'Pelvic floor muscle training'.)

Stimulatory devices — Clitoral vacuum suction devices and vibrators are sometimes recommended to enhance genital engorgement and sexual arousal. Vibrators in particular are frequently recommended in the self-help literature for patients with female orgasmic disorder but are seldom empirically tested. Females with physiologic impairment in genital arousal may especially stand to benefit from stimulation devices.

Different types of stimulatory devices have been compared with one another in a clinical trial but not to a control condition to determine efficacy [35].

Genital cosmetic procedures — Marketing materials for genital cosmetic procedures occasionally make claims about enhancing orgasm, including:

- Collagen injection for “G-spot augmentation”
- Clitoral hood reduction
- Other cosmetic vulvovaginal procedures

There is no credible scientific evidence supporting the efficacy of any of these procedures in treating orgasmic dysfunction.

SUMMARY AND RECOMMENDATIONS

- Patient education should be provided to patients with female orgasmic disorder, preceding and supporting a discussion about treatment options. Detailed information about anatomy and sexual function can correct misconceptions that may be contributing to an orgasmic problem. (See 'Patient education' above.)

- For most patients with primary female orgasmic disorder, we suggest treatment with directed masturbation as a first-line therapy rather than sensate focus exercises or other interventions (**Grade 2C**). (See 'Approach to treatment' above and 'Directed masturbation' above.)

- We favor the use of cognitive-behavioral therapy with sex therapy techniques for female orgasmic disorder that does not respond to education and/or directed masturbation. Cognitive-behavioral therapy is a multicomponent intervention that adds additional behavioral and/or cognitive techniques selectively, tailored to clinical factors identified with each couple:

    - Anxiety contributing to the avoidance of partnered sexual activity – Addressed by augmentation with sensate focus exercises, or if ineffective, with exposure therapy. (See 'Sensate focus exercises' above and 'Exposure' above.)

- Maladaptive thoughts contributing to orgasmic problems – Cognitive therapy techniques to identify and correct unfounded assumptions maintaining negative beliefs. (See 'Cognitive-behavioral sex therapy' above.)

- Relationship problems extending beyond sexual issues – Couples therapy and/or partner communication training can address other relationship problems either prior to or integrated with cognitive-behavioral therapy. (See 'Cognitive-behavioral sex therapy' above.)

- There are no medications with sufficient evidence of efficacy in female orgasmic disorder to recommend their use in clinical practice. (See 'Medication' above.)

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