CHAPTER 12

ORGASMIC DIFFICULTIES IN WOMEN

Although not as prominent a sexual problem as it once was, failure to achieve orgasm continues to be a major complaint of many women. . . . the manner, method, and ease of orgasmic attainment has received wide publicity, and the woman who does not regularly achieve orgasm feels deficient, deprived, and often depressed.

LIEBLUM AND ROSEN, 1989[1]

PROLOGUE

In a study of written descriptions of orgasms obtained from 24 men and 24 women, pronouns were deleted and the accounts given to 70 health professionals who were "blinded" men and women.[5] The latter were unable to distinguish the descriptions on the basis of gender.

Clinical experience suggests that the meaning of orgasm to men and women is not always the same. Men tend to focus attention on their own and their partner's orgasm. Many women also put great weight on the intimacy and closeness that accompanies a sexual experience.

Why are orgasm troubles in women considered separately from phenomena that are known by the same name in men? Is there a difference between the two? When considering only the subjective sensation of an orgasm, probably not. Masters & Johnson,[2] Kaplan,[3] and DSM-IV[4] do not separate men and women. Perhaps even more tellingly, in a study of written descriptions of orgasms obtained from 24 men and 24 women, pronouns were deleted and the accounts given to 70 health professionals who were "blinded" men and women.[5] The latter were unable to distinguish the descriptions on the basis of gender.

What about the equivalency of orgasm and the word "sex?" For many, the answer is that they are not the same. A patient may be better served if a clinician goes beyond a consideration of orgasms only and thinks also about sexual *satisfaction*.[6] Clinical experience suggests that the meaning of orgasm to men and women is not always the same. Men tend to focus attention on their own and their partner's orgasms. Many women also put great weight on the intimacy and closeness that accompanies a sexual experience.

THE PROBLEM

A 27-year-old single woman was concerned about never having an orgasm. Since her late teens, sexual experiences were a regular and satisfying part of three long-term and several brief relationships with men. Despite her usual high level of sexual desire and arousal and the absence of discomfort with intercourse, as well as her obvious pleasure with sexual activity, partners often wondered why she was not experiencing orgasm. They questioned if they were somehow not "doing something right" and generally gave the impression that she was missing out on a universal and gratifying sexual experience. She wondered if something was wrong with her sexual response. She felt that her partners must be knowledgeable about such issues, since they had the wherewithal to compare her to other women

with whom they had had sexual experiences (one was actually explicit in saying so). Over the years, she read books and articles in women's magazines suggesting masturbation as a way of learning to become orgasmic but many attempts at self-stimulation proved unsuccessful. Psychotherapy was directed at focusing on her sexual pleasure rather than whether or not she experienced an orgasm. She was still not orgasmic one year later but the level of arousal that she experienced with sexual activity had markedly increased. She described herself as much more sexually content.

TERMINOLOGY

"Climax" is often used as a synonym for orgasm. On a colloquial level, the word "come" has become the verbal equivalent of orgasm (for women and men), and some women use the more euphemistic words "peak" or "satisfaction."

DEFINITION

Orgasm in a man is not difficult to detect, since it is usually accompanied by ejaculation. The process is more subjective in women, although Masters and Johnson[2] (pp. 128-137) described psychophysiological and measurable phenomena associated with female orgasm such as vaginal contractions. They also described (p.5) three patterns in the sexual response cycle experienced by women. While two patterns reached the level of orgasm, one (designated pattern "B" [see Figure 3-2 in Chapter 3]), reached sustained plateau level response without orgasm apparently occurring. Since their first book, *Human Sexual Response,* described "normal" sexual anatomy and physiology, the implication was thus left that the three patterns of female sexual response were all "normal" and so, too, was a high level of female sexual response without orgasm. Unfortunately, there was no commentary accompanying the description of pattern "B" so the frequency (as well as associated changes in physiology, thoughts, and feelings) of these women remains a mystery.

CLASSIFICATION

Female Orgasmic Disorder is defined in DSM-IV-PC[7] (p. 117) in the same terminology as for the male: "Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. This can be present in all situations, or only in specific settings, and causes marked distress or interpersonal difficulty. This diagnosis is not appropriate if the difficulty in reaching orgasm is due to sexual stimulation that is not adequate in focus, intensity, and duration." Additional clinical information is provided: "In diagnosing Orgasmic Disorder, the clinician should also take into account the person's age and sexual experience. Once a female learns how to reach orgasm, it is uncommon for her to lose that capacity, unless poor sexual communication, relationship conflict, a traumatic experience (e.g., rape), a Mood Disorder, or a general medical condition intervenes. . . ."

Two common clinical presentations of orgasmic dysfunction in women are: (1) lifelong and generalized (also called primary, pre-orgasmia, anorgasmia, and lifelong global) and (2) lifelong and situational (also called situational and secondary). (The term *secondary* can also refer to women who not only experience orgasm through masturbation but who do not experience orgasm "through any type of partner stimulation [and] who define their limited repertoire of stimulation techniques leading to orgasm as problematic").[8] A third form of orgasmic dysfunction is that which is acquired and generalized.

Clinicians commonly hear a concern from a woman that she is experiencing orgasm with masturbation (perhaps easily, and either alone or with partner touch) but not during penile-vaginal intercourse. Masters and Johnson viewed the absence of orgasm specifically during penile-vaginal intercourse (while present otherwise), to be a disorder requiring treatment[9] (pp. 240-241). Many women objected to this idea, since it seemed to echo a previously held idea that orgasms experienced apart from intercourse

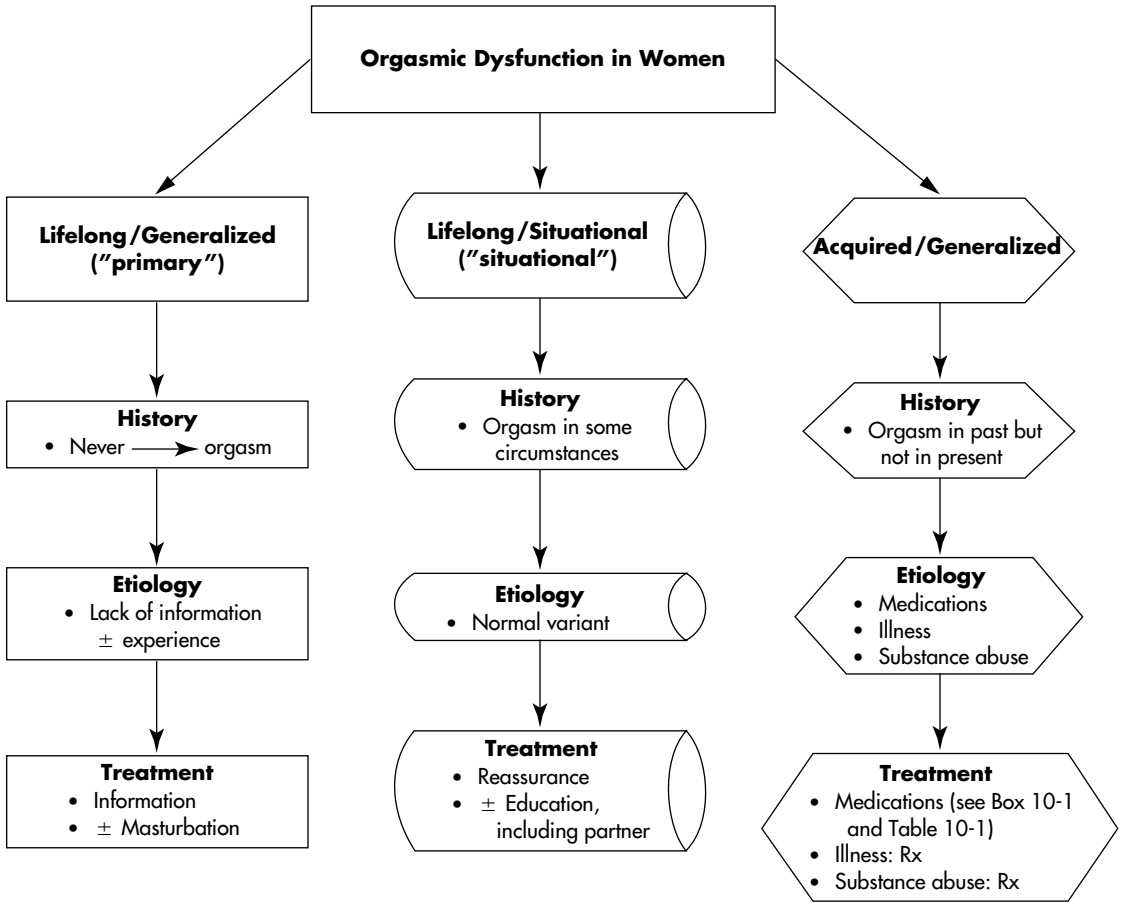

Figure 12-1 Assessment of orgasmic dysfunction in women.

were considered "immature" in contrast to the "mature" orgasms with intercourse. The accumulation of epidemiological information about patterns of orgasmic response in women suggests that orgasm during intercourse is not universal. In fact, one survey found that the *majority* of respondents in partner-related sexual activity usually came to orgasm outside of penile-vaginal intercourse.[10] This new information resulted in a change in the view of health professionals treating women with orgasm concerns to one of thinking that this pattern may not represent pathology but "may constitute a normal variation of female sexuality"[3] (p. 398).

The assessment of orgasmic dysfunction in women is outlined in Figure 12-1.

DESCRIPTION

Lifelong and Generalized ("*primary*")

In the past, many women who reported a lifelong and generalized history of orgasmic dysfunction were considered to be otherwise physically and psychologically healthy. A woman with lifelong and generalized orgasm would describe the following symptoms:

1. Unlike other women she knew, she never had an orgasm
2. She enjoyed sexual experiences with a partner for the closeness but never felt much sexual enjoyment
3. She never tried masturbation
4. She read little or nothing about sex and orgasm
5. She talked to virtually no one about these subjects

Today, women who are concerned about the absence of orgasm often report:

1. A high level of sexual response when with a partner and feeling close to "something"
2. Having read about sexual matters and orgasm
3. Talking to partners about orgasm
4. Having "tried" to masturbate but finding that it "didn't work" (and possibly also used a "toy" such as a vibrator)

Reports of masturbation attempts in the past require more detailed questioning, since they vary from meager (a few opportunities for brief periods) to considerable (many times involving great effort and lengthy duration).

A recently married 26-year-old woman talked to her family doctor about her sexual response. Specifically, she said that while she generally enjoyed sexual experiences with men, she never had an orgasm by any means whatsoever. She read in books and women's magazines about masturbation as a way of experiencing orgasm, little reservation about this approach, and tried it but found it to be sexually frustrating. When asked how many times she tried and for how long, she related that she tried about six times during a two-month period about two years before, and for about five minutes on each occasion. She stopped trying when she experienced little change in her sexual feelings. She also reported that when male sexual partners

stimulated her clitoris, she generally found this irritating and eventually asked them to stop.

The patient's doctor used the opportunity of her periodic pelvic examination and pap smear to explain aspects of female genital anatomy and physiology, about which the patient was not well informed. This was done during the examination by placing the patient in a semi-reclining position while she held a mirror that reflected her genitalia, so that she could more easily understand the doctor's explanation.

After the examination, the patient was encouraged to buy and read a self-help book about women and orgasm and to masturbate at home several times each week for a much longer period of time (at least 15 to 30 minutes) before she stopped. When she returned as scheduled three weeks later, the patient reported the following:

- That she purchased and read the recommended book
- That she experimented with self-stimulation as suggested
- That she experienced a high level of arousal in the process

She was encouraged to continue, and to direct her husband in stimulating her as she might do when alone. Three weeks after that visit, she reported having orgasms regularly when alone since shortly after the previous visit. She also described being less shy with her husband, more candid in her directions, and reaching a much higher level of arousal with him. She was confident that orgasm during sexual activity with her husband would eventually occur.

Lifelong and Situational ("situational")

Women who are situationally nonorgasmic on a lifelong basis usually report that with masturbation they have no difficulty coming to orgasm. (Some may, alternatively, describe infrequent orgasms with a partner.) Some may be orgasmic with partner-related sexual practices other than intercourse and, in general, describe sexual experiences as quite pleasurable. A lack of orgasm usually extends over a lifetime of sexual encounters for the woman (although it is not unusual to hear that orgasm during intercourse occurred once or a few times in the past). Sometimes this pattern of response is presented as a sexual concern. With greater depth of questioning, the woman often says that orgasms with intercourse would be her preference if they could easily happen. However, she states that she feels quite satisfied if she can come to orgasm in some form or another when with her partner, (e.g., with oral stimulation) and that the notion that this must occur specifically with intercourse derives more from the wishes of her partner rather than herself.

Acquired and Generalized

In the acquired and generalized form, the woman reports the recent loss of the ability to come to orgasm by any means whatsoever with a partner or when alone, or alternatively, a recent change in her sexual response pattern such that orgasm occurs only after an unusually lengthy process.

A 39-year-old woman was seen because she recently became nonorgasmic. She was in a harmonious lesbian relationship for the past 10 years. The quantity of sexual activity was considerably greater initially but diminished over the years, largely because of a discrepancy in sexual desire between the two (the patient's partner was less interested). Sexual events were qualitatively uncomplicated. In the past, both were easily orgasmic and the patient masturbated to orgasm several times each week (an experience that she highly valued) between sexual times with her partner. She (the patient) had mild episodes of depression in the past that were treated with psychotherapy. However, more recently, she had a more severe episode and she accepted the inclusion of antidepressant medication (an SSRI) in her treatment. Within a week, she noticed that coming to orgasm with masturbation was becoming more difficult, and shortly after she found that achieving orgasm became impossible by any means (despite continued desire and a high level of arousal). Even though she felt improvement in her mood, the medication was changed because of the sexual side effect. When she became orgasmic once again, however, her symptoms of depression worsened. It proved difficult to find a medication that was effective in treating her mood problems without also causing a loss of orgasm. The benefit of the antidepressant was so substantial that she chose abandoning her orgasms for what she expected to be a limited period of time.

EPIDEMIOLOGY

In response to a question in the Laumann et al. study ("In the last 12 months, has there ever been a period of several months or more when you were unable to come to a climax?") 24% of women respondents said "yes".[11] This was the second most common sexual dysfunction reported by women (the first was "lacked interest in sex"). Orgasm difficulties in women were more often associated (p. 371) with the following:

In response to a question in the Laumann et al, study ("In the last 12 months, has there ever been a period of several months or more when you were unable to come to a climax?") 24% of women respondents said "yes".[11] This was the second most common sexual dysfunction reported by women.

1. Less education (30% of those who had "less than HS")
2. Low income (27% of those who were "poor")
3. Impaired health (33% of those who were in "fair" health)
4. Personal unhappiness (40% of those who were "unhappy most times")
5. Younger age (less than 40 years old)
6. Marital status (highest [29%] in divorced women)
7. Race (highest [29%] in black women)
8. Religion (highest [29%] in women who reported "none")

Information on subclassification can be gained from a review of community based research on the epidemiology of orgasmic dysfunction in women.[12] Various studies show that 5% to 20% of women have never, or infrequently, experienced orgasm. In the language of DSM-IV-PC, such women would be classified as having the lifelong

and generalized form of orgasmic dysfunction.[7] There is inadequate data on the frequency of the situational, and acquired and generalized forms.

In a review of the frequency of orgasmic problems in women as the presenting problem in sex therapy clinics, there was a reported range in several studies from 18 to 76%[13] (p. 42). Variations probably relate to the year the particular study was conducted (several are from the 1970s and early 1980s) and the focus of the clinic from which the particular report emerged.

ETIOLOGY

Most of the comments about the etiology of orgasmic dysfunction in women are general and have not been made in relation to any particular subtype. After reviewing the literature on physiological, sociological, psychological and interpersonal, and cultural factors that might influence orgasm in women, Morokoff concluded that ". . . one association is clearly uncontested: Birth later in the century is related to higher frequency of orgasm[14] (p. 156). Whatever cultural changes in attitude toward female sexuality are at work, it seems possible that women who are better educated, have higher social standing, and/or do not have rigid religious morals have been more easily influenced."

Gebhardt related the experience of orgasm to the extent of happiness of a woman in her relationship. He found that a certain group of women (35% to 41%) reached "coital orgasm" regardless of the degree of contentment.[15] Since the percentage was appreciably higher (59%) in women from "very happy" marriages, he concluded that there were also women who were quite sensitive to the state of their relationship and who would not experience orgasm unless the quality of this alliance was at a high level.

While the importance of psychological issues in the possible causes of orgasmic dysfunction remain unclear from a research perspective, they are difficult to ignore clinically.

A 27-year-old woman, recently separated after a five year marriage, was referred because of never having been orgasmic. In her previous sexual encounters, she was usually interested, had no difficulty becoming vaginally wet, and did not experience pain with attempts at intercourse. She described many of the physiological phenomena associated with a high level of arousal and felt herself "close," at which point "something would happen." Her arousal level and her feeling of sexual desire would drop precipitously. The same pattern existed with other partners before her marriage, as well as with masturbation.

She wondered about sexual abuse during her childhood but had no memory of any such experience. However, she also described a family-of-origin where her father was uncommunicative, unaffectionate, and critical. As an adult, she found relationships with men difficult, particularly in the areas of trust and control. She felt that her distrusting attitude toward men derived directly from her family and, moreover, was underlined by her discovery of a relationship between her husband

and another woman.

After one year of psychotherapy, she had a better understanding of the origins of her attitudes toward men and how they shaped her life in the present. She also felt more sexually responsive for longer periods than had been the case in the past, although to her chagrin, she remained nonorgasmic. However, she was optimistic that this situation might change.

Orgasmic dysfunction that is acquired and generalized can result from various medications, illnesses, and abused substances. However, as compared to impaired ejaculation/orgasm in men, there seems to be considerably less specific information in the literature on the effects of these phenomena on orgasm in women (see "Delayed Ejaculation/Orgasm" in Chapter 10). Segraves comments that women may be less likely to report orgasmic difficulty than men, since they often are more prepared to attribute the problem to an interpersonal conflict than a biological explanation.[16] Although his statement was made in relation to antidepressant medications, it is equally valid in other situations as well, and hence it is necessary to ask specific questions when determining the presence of side effects.

Women may be less likely to report orgasmic difficulty than men, since they often are more prepared to attribute the problem to an interpersonal conflict than a biological one.[16]

Some medications used in psychiatry, to control high blood pressure and other ailments seen in medical practice have a particular predilection for interfering with the orgasm part of the sex response cycle (see Appendix III).[17] Psychiatric drugs that have a specific effect on orgasm in women have been reviewed.[16,18,19] Antidepressants (tricyclics, MAOIs, and SSRIs), antipsychotics (some phenothiazines), and antianxiety drugs (some benzodiazepines) are reported as causing anorgasmia in women. In a recent (1997), comprehensive, and family-practice-oriented report on the sexual side effects of medications, Finger and his colleagues provided information on *all* such effects (not only those related to one part of the sex response cycle), specified the nature of the problems encountered, commented on their relative frequency, and included gender-specific observations (see Appendix III).[20] Some of their notations are relevant to the issue of orgasmic dysfunction in women.

Some medical disorders result in symptoms that affect orgasmic response for men and women. Specific observations on diabetes[21] and multiple sclerosis (MS) in women[22] are reported. One study on sexual problems in women with MS refers to "difficulties" in achieving orgasm. The authors of another study[23] on the same subject found that when a patient had genital sensory disturbance, the kind of sexual practice that occurred became significant when considering whether or not the patient came to orgasm. Three sexual practices were described:

- Intercourse, least effective
- Oral stimulation, intermediate
- Manual stimulation, most effective

Studies of the effects on alcohol use on sexual expression in women are confusing. In a study of the effects of acute intoxication on a group of 18 university women subjects,[24] alcohol was shown to result in a progressively greater depressant effect on

orgasmic response as blood levels increased. Specifically, alcohol was associated with longer latency to orgasm and diminished intensity of the feeling but, paradoxically, greater sexual arousal and pleasure associated with orgasm.

In an attempt to obtain more information on the effects of alcohol on the sexual activity of nonalcoholic women, a prospective study involving daily logs of alcohol intake and sexual activity was conducted on 69 subjects.[25] Three groups were defined:

- No alcohol
- Moderate intake
- Heavy consumption

The only significant finding was that female-initiated sexual activity occurred twice as often *without* alcohol (versus with alcohol). No significant effects were found on sexual arousal, pleasure, or orgasm. These findings indicate errors in retrospective accounts on the stimulative effects of alcohol use on sexual expression in women.

INVESTIGATION

History

History-taking provides core information. Issues to inquire about and questions to ask include:

1. Duration (see Chapter 4, "lifelong versus acquired")

Suggested Question: "**HOW LONG HAS THIS (NOT COMING TO ORGASM) BEEN A CONCERN TO YOU?**"

(Comment: asking about a non-experience is admittedly rather awkward).

2. Partner-related sexual experiences other than intercourse (see Chapter 4, "generalized versus situational")

Suggested Question: "**DOES YOUR HUSBAND (PARTNER) TOUCH YOUR GENITAL AREA WITH HIS FINGERS OR HIS MOUTH DURING LOVE MAKING (OR SEXUAL) TIMES TOGETHER?**"

Additional Question: "**HAVE YOU EVER COME TO ORGASM THAT WAY?**"

3. Masturbation experience (see Chapter 4, "generalized versus situational")

Suggested Question: "**HAVE YOU HAD EXPERIENCE WITH STIMULATING YOURSELF OR MASTURBATING?**"

Additional Question if the Answer is Yes: "**HAVE YOU EVER COME TO ORGASM WITH SELF-STIMULATION OR MASTURBATION?**"

Additional Question: "HAVE YOU EVER USED A VIBRATOR?"

Additional Question if the Answer is Yes: "DID YOU COME TO ORGASM WHEN YOU DID?"

4. Level of arousal (see Chapter 4, "description")

Suggested Question to a Woman who has not Experienced an Orgasm: "IF YOUR COMPARE YOUR SEXUAL EXCITEMENT TO CLIMBING A MOUNTAIN AND ORGASM IS THE PEAK, WHAT HEIGHT DO YOU ACHIEVE WHEN THE TWO OF YOU MAKE LOVE?"

Additional Question if Husband (or partner) Touches Woman with Hands or Mouth: "WHAT ABOUT WHEN YOUR HUSBAND (PARTNER) TOUCHES YOU WITH HIS HANDS OR MOUTH?"

Additional Question if the Patient has Experience with Masturbation or Use of a Vibrator: "WHAT ABOUT WHEN YOU WERE MASTURBATING (OR USING A VIBRATOR)?"

Additional Question if Woman has been Orgasmic: "COULD YOU DESCRIBE WHAT AN ORGASM FEELS LIKE PHYSICALLY?" "PSYCHOLOGICALLY?"

5. Psychological accompaniment (see Chapter 4, "patient and partner's reaction to problem")

Suggested Question: "WHAT ARE YOU THINKING ABOUT WHEN YOU HOPE FOR AN ORGASM AND IT DOESN'T OCCUR?"

Additional Suggested Question: "WHAT DOES YOUR HUSBAND (PARTNER) SAY AT SUCH TIMES?"

Physical Examination

The physical examination is usually unproductive diagnostically in an apparently healthy woman but can be important when conducted for educational purposes.

Laboratory Examinations

No specific laboratory examinations appear useful in an apparently healthy woman.

TREATMENT

Lifelong and Generalized

"Directed Masturbation" is the preferred treatment method and, in principle, involves education, self-exploration and body awareness, and encouraging the patient to masturbate to first experience an orgasm by herself before expecting it to happen when sexually active with a partner.[26] The objective of this approach is for the woman to initially become comfortable with the experience of orgasm when alone, with the hope

that she will subsequently feel equally comfortable when experiencing an orgasm during partner-related sexual activities such as intercourse or oral stimulation. Alternatively, or in addition, she could teach her partner to stimulate her in the same manner as she learned to stimulate herself. Several studies have show this approach to be beneficial and even superior to other treatment procedures.[27,28]

Orgasm initially experienced through masturbation was helpful to a great many middle-class women in the 1970s and 1980s who were born in North America and continues to be widely used as a treatment procedure. However, since the "sexual revolution" in the 1970s, the availability of books on the sexuality of women, sexual information in women's magazines, and the appearance and discussion of explicit sexual issues in movies, videos, and the Internet have provided women (and men) with a substantial amount of sexual information. The resulting change in self-acceptance and self-awareness has greatly affected all aspects of the sexuality of women including knowledge about body function generally and orgasm specifically. As a consequence, most adult women are better informed about their body function in a sexual sense than their counterparts in the 1970s and early 1980s. However, patients who have sexual concerns sometimes avoid reading the information available and may need encouragement to do so. Primary care clinicians are in a particularly advantageous position to provide such assistance. Provision of information and encouragement might be especially valuable to certain groups of women such as teens and adults who immigrated to North America from countries where gender roles are rigid and women are clearly subservient to men (especially in relation to sexual practices).

In a study that has particular applicability to primary care, a 15-session treatment program was compared to a four-visit program.[31] Both were equally effective in helping the woman come to orgasm with masturbation, and the authors concluded that . . . "therapist contact time can be reduced without loss of effectiveness" and that lifelong and generalized orgasmic dysfunction can be viewed as a "skill deficit."

When supplying information and promoting the directed masturbation approach, one method is to proceed step-by-step through the process of learning to masturbate to the point of orgasm. If the major etiological factors are, indeed, lack of sexual knowledge and experience, the number of visits required and the extent of health professional involvement may be minimal and therefore easily within the pattern of practice in primary care. A less time-consuming approach is to suggest to the patient that she read and use one of the readily available self-help soft-cover books describing women's sexual response in general[10] and masturbation techniques in particular.[29,30] In a study that has particular applicability to primary care, a 15-session treatment program was compared to a four-visit program.[31] Both were found to be equally effective in helping the woman come to orgasm with masturbation, and the authors concluded that " . . . therapist contact time can be reduced without loss of effectiveness" and that lifelong and generalized orgasmic dysfunction can be viewed as a "skill deficit." One of the self-help books[29] also has an accompanying videotape that many women find useful (available through Focus International, 1-800-843-0305).

Many women are currently knowledgeable about some sexual aspects of female body function. However, many are unaware of and curious about the details of female genital anatomy (understandably, because the vulva is ordinarily hidden from view and comparisons between girls are therefore not made in earlier developmental years, as often happens with boys in school shower rooms). Many women thus welcome the

reassuring opportunity to compare themselves anatomically to others through the use of a self-help book with color photographs showing the panorama of vulvar shapes.[32]

Vibrators, fantasy, and Kegel's exercises have been suggested as adjuncts to directed masturbation, particularly when ordinary techniques do not achieve the objective of the woman coming to orgasm. On the basis of clinical experience, use of a vibrator can be helpful, since the intensity of the stimulation can not be matched by other methods. Some professionals are concerned about the development of dependency on a vibrator[3] (pp. 388-389); others are not[28]. Vibrators are easily available at pharmacies, department stores, and "sex" shops. No single type is judged superior. Information about vibrators is available in a specific self-help book on this subject.[33] Physicians can arrange for vibrators to be "dispensed" by a specific pharmacy to minimize patient embarrassment.

Books and films that encourage the use of erotic fantasy during sexual activity may also be useful as an adjunct. In a study of "reasonably normal married women," the occurrence of sexual fantasy during intercourse was found to be common and one conclusion derived was that it "could be used adaptively to enhance sexual interest".[34] In another study, women with a sexual desire disorder were found to have significantly fewer sexual fantasies than controls who described a "satisfactory sexual adjustment".[35] From these and other investigations, it is thought that women with desire disorders and other sexual dysfunctions might derive benefit from creating fantasies if they did not experience such phenomena in the ordinary course of sexual events. Books describing sexual fantasies in women can be used as a method of assisting women in learning to fantasize. An example of such a book is *Herotica* 2.[36]

In relation to the sexually arousing effects of films on women, one study showed that the subjective experience of arousal appeared to be greater in women-made films as compared to those made by men, although the genital response to both was described as substantial.[37]

Some clinicians also promote the use of "Kegel's exercises".[38] Kegel was a urologist who taught women who were experiencing stress incontinence to strengthen their pubococcygeus muscle by repeatedly contracting their perivaginal muscles. In the process of doing this, some women reported an increase in their perception of genital sensations and in the frequency of orgasm. Hence the notion was developed that such exercises be used adjunctively in the treatment of orgasmic dysfunction. In nondysfunctional women (and consistent with Kegel's original observations), Kegel's exercises have shown to increase subjective ratings and physiological measures of arousal.[39] However, in women with orgasmic dysfunction, such exercises have not proven to be helpful with the lifelong and generalized form or the situational form (the latter despite an increase in pubococcygeal strength).[40] Whatever beneficial effects exist may derive from an increased focus of attention of the patient on her genitalia.

LoPiccolo and Stock report that of approximately 150 women treated with directed masturbation, "about 95%" were able to reach orgasm through masturbation.[8] "Around 85%" were also able to come to orgasm with the direct stimulation of a sexual partner. "About 40%" of these women were able to also experience orgasms via penile-vaginal intercourse.

In accordance with the concept that orgasm with a partner (e.g., with touch not including intercourse) is a normal variation in the sex response cycle experienced by women, most clinicians who treat people with sexual difficulties approach this concern by "normalizing," and providing information and reassurance to the patient.

Lifelong and Situational

In accordance with the concept that orgasm with a partner (e.g., with touch but not with the thrusting movements of intercourse) is a normal variation in the sex response cycle experienced by women, most clinicians who treat people with sexual difficulties approach this concern by "normalizing," and providing information and reassurance to the patient. One aspect of this reassurance is to help the patient place the issue of how an orgasm occurs in perspective. Doing so might involve clarification of the notion that, while pleasure is one of the desired "outcomes" of sexual activity and pleasure and orgasm are connected, if the woman is left feeling inadequate because orgasm does not occur with a specific sexual practice, this feeling could substantially interfere with her sexual pleasure.

A 35-year-old married woman was referred because she was anorgasmic. She was seen alone because she was taking a summer course in a city that was not where she ordinarily lived. Her family remained at home. In the course of history-taking, it quickly became apparent that she regularly and easily experienced orgasm with touch (her own or her husband's) but not during intercourse, a situation that she and her husband thought to be abnormal. Information was given to her about the variability of orgasm experiences in different women, and reading matter on this subject was suggested. When she returned several weeks later for a second (and final) visit, she summarized the interval as follows:

1. She talked with her husband on the telephone on the evening after the first visit
2. She indicated that her own concerns had greatly diminished
3. She reassured her husband about her normality
4. The couple concluded that they did not have any sexual difficulties

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Verbal reassurance about the normality of not experiencing orgasm during intercourse is powerfully assisted by also referring the patient to published information on this subject. For example, the Hite Report concerning sexuality in women declared that about two thirds of the 3,000 women who were surveyed reported that although they were usually orgasmic, they did not have an orgasm when penile-vaginal intercourse was occurring.[10]

One method used to treat the concern about not experiencing orgasm during intercourse is to provide information about "the bridge maneuver"[41] (p. 87-93). This approach initially involves the patient (with fingers or vibrator) or her partner bringing her to orgasm by direct clitoral stimulation, and the partner then entering her vagina while orgasm is taking place. Subsequently, vaginal entry occurs just before orgasm which, theoretically, would be provoked by penile stimulation alone.

A 37-year-old woman, married for 12 years, described a concern that she never had orgasms during intercourse. Her husband accompanied her to the appointment but

remained in the background. In response to questions, he indicated that he was supportive of what she wanted but at the same time was quite content with their present sexual experiences.

She was regularly and easily orgasmic alone with masturbation and, as well, when her husband stimulated her clitoris with his fingers or orally. She was not reassured when given information indicating that her sexual and orgasmic response pattern was within the range of normal. However, she did not want to give up her objective of orgasm during intercourse.

The approach used was to provide information about the "bridge maneuver" to the patient and her husband, and to see them again in several weeks. During the follow-up visit, both partners reported the following:

1. Having tried the technique twice without any change
2. Less concern on her part about how she would experience orgasm
3. Both felt better about their relationship, since they talked more about nonsexual issues

Male partners tend to be more involved than was the case in this story. In addition to their current partner, women with orgasmic difficulties have often been questioned in the past about the sexual response of other partners. Male partners often imply that 'having an orgasm during intercourse is important to my sexual pleasure and so it must be for you too. If you are not having the same kind of experience as I am, you must not be enjoying yourself. Something is wrong with this situation'. In addition, there is an unvoiced (although sometimes voiced) concern by the man that he is doing "something wrong" and is therefore a "lousy lover." The man in this situation often seems to have difficulty accepting his partner's reassurance. However, the same reassurance given to the man from a health professional authority seems to be quite powerful. Thus it is important to see both partners together.

Acquired and Generalized

Clarifying the possible etiological role of medications, illness, or substance abuse is essential if this is not already apparent to the patient. Medications that interfere with orgasm are outlined in Appendix III. Strategies for managing delayed ejaculation/orgasm resulting from medication use were reviewed in Chapter 10 (see "Delayed Ejaculation/Orgasm, Box 10-1, and Table 10-1). These same treatment approaches apply to men and women.

INDICATIONS FOR REFERRAL FOR CONSULTATION OR CONTINUING CARE BY A SPECIALIST

1. Lifelong and Generalized: for the woman who experiences this syndrome but who is also sexually uneducated and inexperienced a directed masturbation treatment program with appropriate reading materials should be implemented. For the woman who is sexually educated and experienced, the approach is not so

clear. If she is focused on orgasm rather than her feelings of pleasure and does not respond readily to reassurance about the likely positive outcome, referral to a sex specialist might be helpful.

2. Lifelong and Situational: most patients respond positively to an approach that normalizes their experience while at the same time not minimizing their concern. It may be essential to direct this message to the partner as well. A patient who does not want to accept this pattern as a normal variant should be referred to a sex therapist.
3. Acquired and Generalized: when orgasms were a feature of a woman's sexual response in the past but cease to be so in the present, a search for some biological explanation should be made. A physician needs to be involved if the primary care professional is not an MD. When a medication is found to interfere with orgasm, the clinician should make use of the information in Box 10-1 and Table 10-1 in Chapter 10. Illnesses and substance abuse should be specifically treated, since the sexual phenomena are usually symptoms rather than disorders. Clinicians must always consider the possibility that disrupted sexual function could be the presenting symptom of a disorder rather than, for example, the side effect of a medication.

SUMMARY

Orgasmic dysfunction is the second most common problem among women in the general population (24%) but appears as less of a clinical complaint then it did a decade or two ago. When a concern does surface, it can take one of three forms:

1. Lifelong and generalized (primary): the woman never had an orgasm by any means (5% to 10% of women)
2. Lifelong and situational: the woman is orgasmic by one means (e.g., masturbation) but not by other means (e.g., intercourse) (very common)
3. Acquired and generalized: the woman has lost the capacity that she once had to come to orgasm (infrequent in a healthy population).

History-taking is essential in the investigation of the complaint of orgasmic dysfunction (physical and laboratory examinations are distinctly less helpful [other than for educational and reassurance purposes]) in an apparently healthy woman. The lifelong and generalized form is usually a result of lack of awareness of sexual issues affecting women and is responsive to educational input and initial experience of orgasm through masturbation. The concept of the generalized and situational form as a problem requiring treatment has changed substantially so that today this pattern is considered a "normal" variant of female orgasmic response. Women with this concern are generally responsive to reassurance although this often involves the partner as well. The acquired and generalized form usually results from medication side effects, symptoms of illness, or direct effects of abused substances. When a side effect of medications is responsible (see Appendix III), several treatment approaches (see Box 10-1 and Table 10-1 in Chapter 10) can be employed. Only in the occasional instance does specialized care seem necessary for any of the three forms described.

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