

# Female Orgasmic Disorder

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One of the most reported sexual problems in women relates to orgasm. For women who receive treatment for female orgasmic disorder, the prognosis is good.

here is no universally accepted definition of orgasm in women. Meston et al have defined it as "a variable, transient peak sensation of intense pleasure creating an altered state of consciousness, usually accompanied by involuntary, rhythmic contractions of the pelvic striated circumvaginal musculature, often with concomitant uterine and anal contractions and myotonia that resolves the sexually-induced vasocongestion (sometimes only partially), usually with an induction of well-being and contentment."1

The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR) defines female orgasmic disorder (FOD, formerly inhibited female orgasm) as a persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase.2 The diagnosis requires that another axis I disorder does not account for the orgasmic dysfunction better than FOD and that the dysfunction is not exclusively due to a direct physiologic effect of a substance or a general medical condition.

According to the DSM-IV-TR, FOD can be lifelong or acquired, generalized or situational, or due to psychologic or combined factors. It should be emphasized that the presence of a sexual excitement phase is required to diagnose FOD. The presence of decreased desire for sexual activity, aversion to sexual contact, or decreased lubrication represents different disorders that may coexist with anorgasmia.

#### **EPIDEMIOLOGY**

Investigators from the National Social and Health Life Survey noted that the second most frequently reported sexual problems in women are related to orgasm.3 In this study, 24% of a random sample of 1,749 US women reported having no orgasms for at least several months in the previous year. Due to the lack of well-controlled studies, the wide variability in definition, and the lack of objective diagnostic markers for FOD, the available epidemiologic evidence most likely represents an underestimation of the true prevalence of this condition.

#### **FEMALE SEXUAL RESPONSE**

In 1966, Masters and Johnson reported that the female (and male) sexual response is characterized by a sequential progression of events starting with sexual interest and culminating in orgasm.4 This view likely oversimplifies the nature of the female sexual response. More recent theories, such as Basson's model, suggest that the female sexual response is much more complex than originally understood and integrates emotional intimacy, sexual stimuli, and relationship satisfaction.5 Numerous laboratory studies have shown a "disconnect" between objective and subjective arousal in women.<sup>6,7</sup> In other words, if a woman is not psychologically and physically receptive to sexual contact, her chances of achieving orgasm are decreased.

#### **PHYSICAL CONSIDERATIONS**

Erotic stimulation resulting in female orgasm can originate from a variety of genital and nongenital sites. Although the clitoris and

## FOCUS**POINT**

The second most frequently reported sexual problems in women are related to orgasm.

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vagina are the most common sites of stimulation that result in an orgasm, stimulation of other body sites (eg. periurethral glands, breasts, nipples, or mons) can also trigger an orgasm. Scientists, however, are beginning to shift their focus off of the clitoris toward the most important sex organ—the brain.

Researchers are beginning to understand how the central nervous system functions prior to and during orgasm by recording how the brain activates (or shuts down) during orgasm. Some researchers are training women to increase their orgasmic capacity by letting them observe their own personal sexual brain patterns (sexual biofeedback).8 Mental imagery and fantasy have also been shown to facilitate orgasm in some women.9 Interestingly, wakefulness is not a requirement for orgasms, as they have been reported to occur during sleep.10 Others have found that spontaneous orgasm can occur without any obvious stimulus.11

### **PSYCHOLOGIC CONSIDERATIONS**

Depression and anxiety may cause sexual dysfunction in general, including anorgasmia. If the axis I disorders are present, they should be treated first. A lack of emotional closeness, as well as anger, resentment, and lack of trust can decrease sexual desire and inhibit the orgasmic response. In addition, boredom in sexual activity, embarrassment about sharing with their partner what they require for sexual satisfaction, and religious beliefs may contribute to secondary FOD. These sociocultural beliefs are often deeply entrenched and must be delicately managed in a therapeutic setting.

A recent study found a correlation between EQ (emotional intelligence) and orgasmic capacity. The study suggests that the more emotionally intelligent a woman is, the more orgasms she has.<sup>12</sup> Women who have self-confidence, empathy, access to their own emotions, and comfort with emotional intimacy (all measures of EQ) are better positioned to achieve orgasm than are women who lack these traits.

There is no consistent evidence that psychosocial factors alone can lead to FOD.13 Nevertheless, psychologic factors have a strong impact on the female sexual response and the ability to achieve orgasm. It is important to keep in mind that a number

## **TABLE. Evaluating the Patient** With Female Orgasmic Disorder

- Establish rapport
- · Medical, psychologic history
- · Regularity of orgasm
- · Relationship issues
- · Neurologic disorders
- · Hormonal disorders
- · Physical examination
- · Laboratory work-up
- Vaginal pH

of illicit drugs or prescribed medications, especially alcohol, selective serotonin reuptake inhibitors, antipsychotics, and antihypertensives may negatively affect sexual functioning.

#### **EVALUATION**

It is crucial that the clinician establish a rapport that puts the patient at ease, creating an environment where she feels comfortable discussing her sexual issues (Table). The evaluation of a woman with an orgasmic disorder includes a thorough medical and psychologic history. The clinician should assess if the patient previously achieved orgasm (and if so, through what means), the regularity with which she was able to do so, and if her current problem is limited to a specific relationship. Neurologic disorders including multiple sclerosis and diabetic neuropathy, as well as hormonal disorders such as hypothyroidism and decreased androgen levels, should be assessed.

A comprehensive physical examination, including a neurologic examination, should be performed. Laboratory work-up should include blood glucose levels, a chemistry panel (including calcium levels) to rule out any electrolyte abnormalities, and a hormonal panel including androgen, estrogen, testosterone, prolactin, and thyroid hormone levels. A full blood count and vitamin B<sub>12</sub> and

## **FOCUS POINT**

The evaluation of a woman with an orgasmic disorder should include a physical and a neurologic exam.

## **SEXUALITY**MATTERS

**Female Orgasmic Disorder** 

folate levels need to be checked to rule out a peripheral neuropathy. Most of these tests can be performed in a primary care office. Additionally, a vaginal pH may be useful.

#### **TREATMENT**

#### **Psychotherapy**

The cornerstone of treatment for FOD is cognitive behavioral therapy (CBT). Evidence regarding the effectiveness of psychoanalytic or psychodynamically oriented therapies is inconclusive. More recent approaches are focused on the importance of a woman being able to reach orgasm as desired under any circumstance. CBT for FOD focuses on promoting changes in attitudes and sexually relevant thoughts.

The underlying assumption of CBT-based interventions is that orgasmic ability and satisfaction can be increased by reducing sex-associated anxiety and cognitive distortions. This strategy is based on the belief that many women develop performance anxiety, embarrassment, or guilt related to having an orgasm with her partner, thereby misdirecting her attention from enjoying

erotic stimulation to performance-related concerns.

Lastly, purely behavioral exercises involving directed masturbation have been effective for treating FOD in a variety of modalities including bibliotherapy (reading books recommended by the therapist), as well as group, individual, or couples therapy. Meston and Levin reported that masturbation was an empirically valid and effective treatment for women with lifelong, generalized FOD.<sup>13</sup>

#### Pharmacotherapy

A number of medications have been evaluated for the treatment of female sexual dysfunction; bupropion and sildenafil citrate are probably the most commonly used. To date, there is no FDA-approved medication for the treatment of FOD.

#### Bupropion

Bupropion (Wellbutrin®), a dopamine-agonist class of antidepressants, has emerged as a treatment for FOD. Bupropion was studied in nondepressed women with hypoactive sexual desire disorder and was shown to sig-

## about the natural course and prognosis of women with untreated FOD.

FOCUS**POINT** 

Little is known

## **Coding for Female Orgasmic Disorder**

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There is an ICD-9 code for the title of this article:

#### 302.73 Female orgasmic disorder

The evaluation and management of this disorder will require several office visits. It is recommended that the clinician perform a comprehensive physical examination as well as a thorough medical and psychologic history. Following these evaluations, the majority of the visits will be counseling and coded using time as the determining factor.

For an established patient, code **99215** corresponds to 40 minutes of face-to-face time. Or, you can use the prolonged physician service codes, **+99354** and **+99355**. This would be determined by whether the counseling session is added on to a regular office visit. If not, then use time as the determining factor for the office visit.

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

Instructions for management (treatment) and/or follow-up

For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Each of these visits should be documented with the recorded face-to-face time. A summary of what was discussed along with the suggested treatment plan will complete the appropriate documentation.

pH; body fluid, not otherwise specified

The ICD-9 codes that were mentioned in the article are:

302.72 With inhibited sexual excitement
Female sexual arousal disorder
Frigidity
302.73 Female orgasmic disorder
799.81 Decreased libido
Decreased sexual desire

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nificantly improve sexual arousal and orgasm, but not sexual desire.14

#### Sildenafil Citrate

Sildenafil citrate is a phosphodiesterase type 5 inhibitor and is FDA approved for the treatment of male erectile dysfunction. A randomized placebo-controlled trial evaluating sildenafil in women with antidepressantassociated sexual dysfunction found the ability to reach orgasm and experience orgasm satisfaction was significantly better for those in the sildenafil group.15

Other clinical trials have shown increased vaginal engorgement in the presence of sexual stimuli, but the subjective experience of arousal was not reliably achieved.16 The fact that objective physiologic arousal, but not necessarily subjective arousal, was documented in these studies reinforces the notion that there is a "disconnect" between objective and subjective arousal in women.

#### CONCLUSION

Female orgasmic disorder can be a challenging condition, for both the patient and the clinician. Little is known about the natural course and prognosis of women with untreated FOD. Some cases of the acquired and situational types seem likely to remit spontaneously. Patients with lifelong and generalized types of FOD appear to have a good prognosis with treatment but an uncertain prognosis without treatment. Fortunately, in recent years there has been increased interest and research in women's sexual health, which hopefully will facilitate improved treatment options for women with sexual health concerns.

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