

Title: Assessment and management of Female Orgasmic Disorders

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Executive summary:

Female orgasmic disorder is recurrent and persistent inhibition of the female orgasm, characterized by the absence or delay of orgasm after a normal sexual excitement phase, or a marked decrease in the intensity of orgasmic sensations. Subjective sexual arousal, genital arousal are intact. There is subjective distress due to inability to achieve orgasm. It is seen in around 4-7% Indian women and the common age groups are 31-40 years and 41-50 years. It has a multifactorial biopsychosocial etiology. Assessment includes a detailed sexual history, including masturbation, effect of menses, history of sexual abuse or trauma, characterization of orgasmic difficulties (lifelong/acquired; generalized/situational), level of personal distress, relationship factors, trauma history, medical or surgical comorbidities, gynaecological and obstetric history, mental health screening, medication review, menopausal status, and physical examination. Appropriate laboratory tests when clinically justified - haemogram, hormone tests, screening for metabolic dysfunction and cardiovascular problems especially at menopause are indicated. Management is multidimensional. It has a gynaecological and surgical component. Pharmacotherapy plays a role depending on the cause of the female orgasmic disorder. Psychosocial management plays an important role dealing with female orgasmic disorder.

Introduction:

The present article deals with female orgasmic disorders. The scope of the article includes an introduction to the definition and evolution of the concept of the female orgasmic disorder, its multifactorial aetiology, need for and components of comprehensive assessment and management strategies including non-pharmacological and pharmacological management and surgical and gynaecological interventions wherever necessary. Assessment and management of female sexual dysfunctions including orgasmic disorders has been briefly described in the Clinical Practice guidelines of Sexual Dysfunctions of 2017 and should be referred to. (1) The female orgasm is defined as a “state of intense pleasure, has transient peaks, and is variable, usually resulting in an altered state of consciousness, with accompanying contractions of pelvic musculature, which are involuntary and rhythmic. Often associated with contractions of uterine, anal musculature, and myotonia resolving sexually induced vasocongestion and induction of well-being and contentment. (2)” Erotic stimulation of genital areas such as the clitoris, vagina, other areas of the vulva and nongenital areas like the breasts and nipples leads to an orgasm in a female. Orgasms in females can also be achieved through fantasy, mental imagery, and hypnosis. Physical or psychological sexual stimulation is essential to achieve orgasm; however, it has been said that orgasm in females may be achieved using some psychotropic drugs. (3) Female orgasmic disorder is also known as inhibited female orgasm, or anorgasmia., when there is recurrent and persistent inhibition of the female orgasm, characterized by the absence

or delay of orgasm after a normal sexual excitement phase, or a marked decrease in the intensity of orgasmic sensations. In women when orgasm is achieved with noncoital clitoral stimulation but cannot be experienced during coitus in the absence of manual clitoral stimulation are not categorized as anorgasmic. (4) Most women with female orgasmic disorder can feel subjective sexual arousal, genital arousal, and have sexual desires but they are unable to achieve orgasm for a multitude of reasons.

There has been an evolution in the understanding of the concept of 'female orgasmic disorder'. DSM-I identified orgasmic problems under psychophysiological autonomic and visceral disorders, DSM-III recognized it as a sexual dysfunction, defining it as lack or delayed orgasmic response. Distress related to orgasmic difficulties was included in DSM-IV. DSM-V changed further to include the criteria, as seen in Box-2, that key symptoms should be present in two-thirds of sexual encounters and be present for at least 6 months.

International Classification of Diseases-10 (ICD-10) classified sexual dysfunctions as organic and nonorganic. Diseases of the genitourinary system were included in organic sexual dysfunctions and nonorganic sexual dysfunctions were categorized under the section of mental and behavioural disorders. However, in ICD-11, as seen in Box-1, female sexual dysfunctions are in a separate section on conditions related to sexual health and orgasmic dysfunction criteria are the same for both men and women. The specifiers such as acquired, lifelong, situational, and generalized have been introduced to avoid overdiagnosis.

International Society for the Study of Women's Sexual Health (ISSWSH) has defined female orgasmic disorders as, "Persistent or recurrent distressing compromise of orgasm frequency, intensity, timing, and/or pleasure associated with sexual activity for 6 months". Definitions have been for *frequency as* Reduced frequency (diminished frequency of orgasm) or absent orgasm(anorgasmia), *Intensity as* Less intensity (muted orgasm), *Timing as* Too late (delayed orgasm) or too soon (spontaneous or premature orgasm) than desired and *Pleasure as* Orgasm occurs with absent or decreased pleasure (anhedonic orgasm and pleasure dissociative orgasm

disorder) They have also given other specifiers such as lifelong or acquired, generalized, or situational (5)

Box 1- ICD 11 Diagnostic criteria- salient features

Classified under “Conditions related to sexual health”. Has a gender- neutral term, “anorgasmia”. (6)

- Characterised by the absence or marked infrequency of the orgasm experience.
- Significantly decreased intensity of orgasmic sensations.
- In women- this includes a marked delay in orgasm.
- In in men - Male Delayed Ejaculation.
- In spite of adequate sexual stimulation, the desire for sexual activity and orgasm
- episodic or persistent over a period at least several months,
- associated with clinically significant distress.

Inclusions

Psychogenic anorgasmy

Sections/codes in this section

Anorgasmia, lifelong, generalised (HA02.00)

Anorgasmia, lifelong, situational (HA02.01)

Anorgasmia, acquired, generalised (HA02.02)

Anorgasmia, acquired, situational (HA02.03)

Anorgasmia, unspecified (HA02.0Z)

Box 2- DSM 5 TR Criteria-Salient features

1. Symptoms present on approximately 75%–100% occasions of sexual activity
2. Significant delay or absence of orgasm,
3. Significantly decreased frequency and intensity of orgasm
4. Lasting for at least 6 months.
5. It could be lifelong or Acquired
6. Situational or generalized
7. Can be described as mild, moderate and severe.
8. Causes significant distress (7)

Addit
diagno

ment:

1. Partner factors – partner’s sexual problems, partner’s health status
2. Relationship factors – poor communication, discrepancies in desire for sexual activity
3. Individual vulnerability factors – poor body image, history of sexual or emotional abuse
4. Cultural/Religious factors – inhibitions related to prohibitions against sexual activity, attitudes toward sexuality
5. Medical factors relevant to prognosis, course, or treatment (7)

Epidemiology:

Prevalence rates of female orgasmic disorder vary widely for a number of reasons like cultural differences, rate of reporting, varied research methodologies and lack of uniform definitions. This leads to findings of prevalence of approximately 16–28% of women in the USA, Europe, and Central and South America versus 46% in Asian countries. (8) In a study conducted in rural population in South India, out of 787 sexually active female participants 5.67% had female Orgasmic Disorder(FOD) (9). In another study by Avasthi et al (10) FOD was seen in 9% females. Three other large epidemiological studies have found anorgasmia in 4 -7% women. The study by Sathyanarayan Rao et al showed that the prevalence is more common between the age groups of 31-40 and 41-50 years. The prevalence was also affected by literacy and chronic medical illnesses. (9)

Etiopathogenesis of Female Orgasmic Disorder:

Female orgasmic disorders are multifactorial condition resulting due to interaction of biological, psychological, interpersonal, sociocultural, developmental and iatrogenic factors. The etiology is best understood through biopsychosocial model where multiple predisposing, precipitating and perpetuating factors interact to affect the orgasmic capacity. (11, 12) Female orgasm is a complex psychophysiological phenomenon involving sensory, emotional, cognitive, endocrine vascular, and relational components. Therefore, dysfunction of one of the components can lead to abnormalities at one of these levels. (13,14,15)

Neurobiological Factors:

Neurotransmitter abnormalities and hormonal factors:

The role of neurotransmitters is shown in Figure1 and Table 1 shows the female orgasmic dysfunctions caused by abnormalities in neurotransmitters and hormones.

Figure 1: Role of different neurotransmitters

Table 1: Role of Neurotransmitters and hormones in Female orgasmic disorders

Neurotransmitter/ Hormone	Role	Dysfunction
Dopamine	Facilitates orgasm	Delayed orgasm
Serotonin	Inhibits orgasm	Anorgasmia
Oxytocin	Pleasure & bonding	Reduced satisfaction
Nitric oxide	Vasodilation	Poor genital response
Norepinephrine	Sexual excitement	Delayed orgasm
Prolactin	Dopamine inhibition, Post-orgasm inhibition	Delayed orgasm
Oestrogen	Lubrication	Vaginal dryness, dyspareunia, reduced genital sensation, reduced orgasmic intensity

Testosterone	Sexual motivation	Delayed orgasm, reduced orgasm frequency, decreased orgasmic intensity
Thyroid hormone-Hypothyroidism	Energy & libido	Fatigue, low mood, Reduced libido
Thyroid hormone-Hyperthyroidism	Anxiety, emotional instability	Vaginal dryness, orgasmic difficulties

Vascular Factors

Adequate genital blood flow is essential for development of orgasm. Reduced blood flow can lead to reduced engagement, poor, lubrication and diminished orgasmic sensation, which is generally seen in conditions like diabetes mellitus, hypertension, dyslipidemia, smoking, atherosclerosis, and cardiovascular disease.

Neurological Factors

Normal orgasm involves the integrity of several neural pathways, such as the pudendal nerves, pelvic nerves, hypogastric nerves, and the sacral spinal cord circuits, that have been linked to coordinating genital sensation, autonomic arousal, pelvic muscle contractions, as well as central processing of sexual stimuli. Injury or dysfunction of any of these pathways may affect the orgasmic ability. Inhibition of sensory transmission and autonomy of regulation of orgasm may involve neurological disorders as summarized in the table 2.

Table 2 - Neurological disorders causing female orgasmic disorder

Neurological Disorder	Key Mechanisms Leading to Female Orgasmic Disorder
Multiple Sclerosis	Demyelination, sensory deficits, autonomic dysfunction
Parkinson Disease	Dopaminergic deficiency, motor impairment, medication effects
Stroke	Cortical damage, emotional changes, reduced genital perception
Spinal Cord Injury	Interruption of orgasmic pathways, sensory impairment
Peripheral Neuropathy	Reduced genital sensation, impaired sensory transmission
Diabetic Neuropathy	Autonomic dysfunction, sensory loss, vascular impairment
Alcohol-Related Neuropathy	Peripheral nerve damage, reduced genital sensation
Epilepsy	Limbic dysfunction, antiepileptic medication effects
Traumatic Brain Injury	Brain network disruption, cognitive and emotional changes

Dementia	Cognitive decline, impaired sexual response pathways
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Gynaecological factors:

Gynecological conditions have influence over the sensation of the genitals, the structure of the pelvis, pain conditions and sexual operations. Various gynecological disorders can cause female orgasmic disorder. (Table 3)

Table 3 - Gynecological conditions leading to female orgasmic disorders

Gynecological Condition	Key Mechanisms Leading to Female Orgasmic Disorder
Endometriosis	Chronic pelvic pain, dyspareunia, fear of intercourse
Chronic Pelvic Pain Syndromes	Pain anticipation, avoidance behavior, reduced sexual pleasure
Interstitial Cystitis	Pelvic pain, discomfort during intercourse
Vulvodynia	Vulvar pain, dyspareunia, avoidance of sexual activity
Pelvic Floor Dysfunction	Pelvic pain, muscle hypertonicity, impaired sexual satisfaction
Genitourinary Syndrome of Menopause	Vaginal atrophy, dryness, reduced elasticity
Pelvic Surgery	Nerve injury, reduced genital sensation, psychological concerns
Hysterectomy	Altered pelvic anatomy, psychological factors
Pelvic Floor Repair	Nerve damage, discomfort during intercourse
Radical Pelvic Surgery	Extensive nerve injury, reduced genital sensation

Psychological Factors

Psychological factors are strongly related to female orgasm. They are shown in Table 4.

Anxiety disorders are one of the most common psychiatric illnesses affecting sexual orgasm by promoting ‘spectatoring’ (a process in which women become an observer of sexual performance, rather than fully engaging in the sexual activity) which generates intrusive thoughts of self-doubt, which creates cognitive distractions, increases self-monitoring, and interferes with the sexual arousal and orgasmic response cycle. Depression contributes through reduced reward sensitivity, fatigue, and negative self-image which leads to reduced interest in sexual activity and orgasm frequency.

Guilt about sexual activity is another cause of orgasmic dysfunction which commonly arises due to religious prohibitions, conservative upbringing, and internalization of cultural beliefs. This consequently leads to reduced erotic focus, increased inhibitions, and difficulty in surrendering control during sexual activity. Negative body image causes women to become more focused towards appearance rather than the sexual pleasure.

Sexual trauma during childhood and adulthood causes fear conditioning, hypervigilance, emotional numbing, and negative sexual schemas which lead to delayed sexual orgasm, anorgasmia, sexual avoidance and dissociation during intercourse.

Table 4 - Mechanism of Psychological factors in female orgasmic disorder

Factor	Mechanism	Clinical Effect
Anxiety	Spectatoring	Delayed orgasm
Depression	Reduced reward	Low pleasure
Trauma	Hypervigilance	Avoidance
Guilt	Cognitive inhibition	Orgasmic difficulty
Body image	Self-monitoring	Reduced pleasure

Relationship Factors

Recent studies have suggested that the female sexual response cycle is strongly influenced by relationship factors. Factors like persistent marital conflicts lead to decreased emotional safety and lack of trust in a relationship which leads to reduced sexual responsiveness in the relationship. Further lack of communication between partners, because of hesitancy may lead to lack of proper communication about desired stimulation, sexual preferences and fantasies. This further affects sexual stimulation in females. Lack of emotional intimacy is also one of the factors affecting orgasmic satisfaction in females as compare to males.

There are also many cases in which the male sexual partner may have sexual issues like erectile dysfunction, premature ejaculation and low sexual interest. These factors may secondarily affect female orgasmic function.

Sociocultural Factors

Sociocultural factors influence female orgasmic dysfunction due to the restrictive sexual beliefs of society as shown in Table 5. These factors influence sexual expression and orgasm due to lack of sexual education. Additionally, myths and misconceptions may create guilt, shame, and unrealistic expectations thus contributing to orgasmic dysfunction.

Table 5 - Sociocultural factors in female orgasmic disorder

Sociocultural factor		Effect
Poor sex education	women unaware of the genital anatomy and orgasmic response variability	Lack of stimulation knowledge
Religious guilt		Inhibition
Gender norms	sex is meant only for reproduction, women should not initiate sexual activity or female sexual pleasure is inappropriate	Suppression of desire
Sexual myths	vagina orgasm being superior than oral orgasm, masturbation is harmful	Unrealistic expectations
Conservative upbringing	Good women should shun enjoying sex. Guilt and shame about sexual pleasure	Anxiety

Medication-induced Etiopathogenesis

Medication-induced orgasmic dysfunction is a common cause of FOD. Antidepressants, particularly SSRIs and SNRIs are the most common causes of sexual dysfunction through imbalance of neurotransmitters, inhibition of spinal orgasmic pathways and decreased nitric oxide activity. Further, antipsychotics like risperidone, paliperidone and amisulpride cause dopamine blockade, which leads to hyperprolactinemia and sedation, which also affects female sexual functioning. Mood stabilizers like lithium and valproate cause impaired orgasm by interfering with neuroendocrinal system. Other agents like beta-blockers, opioids, oral contraceptive pills, gonadotropin releasing hormone(GnRH) agonists and antiandrogen therapies also effect female sexual functioning.

Developmental and Learning Factors

Female orgasm is influenced by previous sexual experiences. Unsuccessful sexual experiences due to insufficient sexual knowledge, lack of masturbation experience, limited knowledge about sexual preferences and previous traumatic sexual experiences may affect the orgasmic functioning in female. Women who never had knowledge about effective sexual stimulatory patterns may experience primary orgasmic dysfunction for lifelong. Thus, summarizing the biopsychosocial model of female orgasmic disorder in Fig 2.

Figure 2- Summary of factors contributing to female orgasmic disorder

Assessment of Female orgasmic disorder:

The aim of assessment is to determine the probable diagnosis of an orgasmic disorder, to proceed with evaluating the severity and distress it causes and the effect on the relationship and vice versa. The next step is to rule out possible physical causes, psychological and social and interpersonal causes. The use of validated questionnaires and standardised tools can be used to quantify symptom severity and specific problems in areas of desire, arousal, pain and orgasm. (16) (17) (18)

Assessment begins with a detailed history relevant to the presenting complaint as well as history of relevant psychiatric symptoms, followed by gynecological history, a thorough physical examination and necessary laboratory investigations. Rating scales to assess the presence and severity of FOD are useful in diagnosis. Interviewing the sexual partner is equally important. A culturally sensitive atmosphere where vernacular terminologies are used in the language that the patient understands, makes the patient comfortable and helps in the assessment. (5) Box 3 summarizes the clinical assessment of patients with FOD.

Box 3- Clinical Assessment:

- Detailed sexual history including masturbation, effect of menses, history of sexual abuse or trauma
- Characterisation of orgasmic difficulties: onset, duration, frequency, foreplay, factors that enhance the experience of orgasm, precipitating cause if any, distress experienced; aggravating and relieving factors, lifelong/acquired, generalized/situational.
- Current experience of desire, arousal, lubrication, pain, and satisfaction.
- History of relationship factors, its impact on the symptoms, history of partner sexual dysfunction, any ongoing treatment and attitude to it, medical or surgical interventions
- History of treatment taken, use of sexual aids to improve the symptom
- Assessment of psychological factors- assessment of anxiety symptoms, history of trauma, sexual cues giving rise to anxiety, body image disturbances, cognitive distortions of guilt and self-doubt, 'spectatoring', presence of mental illnesses
- History of medical or surgical comorbidities- diabetes mellitus, neurological disease, vascular disease, endocrine disorder.
- Medication review including antidepressants like SSRIs, antipsychotics, mood stabilizers, hormonal therapies, over the counter medications, supplements including gym supplements
- Pelvic floor symptoms (including incontinence - urinary and fecal)
- Focused physical examination where indicated.
- Appropriate laboratory tests when clinically justified - haemogram, hormone tests, screening for metabolic dysfunction and cardiovascular problems especially at menopause

transmitted infections.

Appropriate laboratory tests(as seen in Table 6) to rule out common causes of anaemia, thyroid dysfunction, metabolic dysfunction, cardiovascular fitness and wellbeing should be carried out. (19) Box 4 summarizes Gynaecological and Obstetric assessment.

Box 4: Gynaecological and Obstetric assessment

- History of menarche, regularity, flow, dysmenorrhoea
- History of pregnancy and delivery, history of abortions or miscarriages, complications of pregnancy and delivery if any, post-partum recovery, history of return to sexual activity, lactation, contraception use and contraceptive failures.
- History of menopause: date of last menses, a menopause symptom chart or tracker and menopause rating scale along with the impact it has on sexual desire, arousal, orgasm and pain.
- History of urinary and Faecal incontinence and its impact on sexual function
- Assessment of understanding and beliefs about ageing in general as well as reproductive tract ageing
- Inquiry about cervical cancer, breast disease and sexually transmitted infections including the number of previous partners and type of sexual activity
- A thorough general examination and targeted cardiac, pelvic and neurological

308 **Table 6- Investigations needed for Assessments**
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Clinical Domain	Investigation	Abnormality Identified	Mechanism	Clinical Consequence
General health	CBC	Anaemia, chronic illness	Reduced energy and overall well-being	Contributes to sexual dysfunction
Endocrine	Thyroid profile	Hypothyroidism	Reduced metabolism and libido	Delayed orgasm/anorgasmia
Endocrine	Prolactin	Hyperprolactinemia	Dopamine suppression	Reduced libido and orgasmic dysfunction
Endocrine	Testosterone	Androgen deficiency	Reduced sexual motivation and arousal	Delayed orgasm
Endocrine	Estrogen	Estrogen deficiency (menopause)	Vaginal atrophy, reduced lubrication	Reduced orgasmic intensity
Metabolic	Blood Glucose	Diabetes mellitus	Neuropathy and vascular impairment	Reduced genital sensation, orgasmic dysfunction
Vascular	Lipid profile	Dyslipidaemia/vascular disease	Reduced genital blood flow	Reduced arousal and orgasmic response
Neurological	MRI brain	Pituitary adenoma or neurological lesion	Hormonal dysregulation or impaired neural pathways	Orgasmic dysfunction

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313 **Tools for assessment:**

314 There are various rating scales for assessment of sexual dysfunctions and sexual disorders.

315 These instruments may be general i.e. useful for all sexual dysfunctions and sexual disorders
316 or they may be specific for individual sexual disorders. There are very few scales which are
317 culturally validated and that have been translated in Indian languages. Following scales are
318 useful in assessment of female orgasmic disorder, as shown in Table 7.

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323 **Table 7 - Tools for assessment**

Scale	Name	Description	Advantages	
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Assessment of various sexual dysfunctions (20)	Arizona Sexual Experience Scale (ASEX)	5-item rating scale that evaluates the 4 phases of sexual functioning and 1 item assesses satisfaction with orgasm, ie, sexual drive, arousal with sexual stimuli, vaginal lubrication/ penile erection, the ability to reach orgasm and the satisfaction with orgasm.	Can be used in both the genders. Clinician and self-rated.	
	Change in Sexual Functioning Questionnaire (CSFQ)	It is a 14-items structured interview/questionnaire, which compares sexual functioning with the past before a specific event like an illness or starting of medication, etc. It assesses erectile dysfunction, vaginal lubrication status, dysfunction in orgasm and ejaculation, increase or decrease in desire and frequency, and intensity of sexual contact.	Separate male and female version	
	Sexual Functioning Questionnaire (SFQ)	38 item scale. Assesses sexual functioning over the last one month for libido, sexual arousal, masturbation, orgasm, and ejaculation.	Clinician rated. Specific for people with severe mental illness.	
	Sexual Function Questionnaire	34 item scale. Assesses sexual desire, physical arousal-sensation,	Specific for sexual dysfunctions	

		physical arousal-lubrication, enjoyment, orgasm, pain, and partner relationship	in females. Newer version of 28 items.	
	Derogatis Interview for Sexual Functioning (DISF)	25 item scale for assessment of quality of sexual functioning on sexual fantasy, quality of experience, sexual arousal, sexual orgasm, and sexual drive.	Self -rated and clinician rated	
	Female Sexual Function Index (FSFI)	19 item scale for assessment of arousal lubrication, Orgasm, satisfaction, and pain.	Self -administered. For females	
	Golombok-Rust Inventory of Sexual Satisfaction(GRISS)	Assess quality of sexual functioning on impotence, premature ejaculation, anorgasmia, vaginismus as well changes as in frequency, female avoidance, male and female dissatisfaction from the sexual act	Useful for heterosexual couples. Gives separate final scores for males and females. Good for assessing improvement in therapy.	
Assessment of sexual orgasm(20)	Orgasm Rating Scale (ORS)	40 item, multidimensional assessment and quantification of the psychological experience of orgasm in both men and women. Sensory and cognitive-affective dimensions assessed in the context of solitary masturbation and sex with a partner.	Self -rated, For both genders.	

	Female Orgasm Scale	7 item scale assesses the consistency of female orgasm during partnered sexual activities (eg, intercourse, oral stimulation, self-stimulation with partner present) and overall satisfaction with orgasm frequency and quality.		
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Abbreviations used: ASEX-Arizona Sexual Experience Scale, CSFQ -Change in Sexual Functioning Questionnaire, SFQ- Sexual Functioning Questionnaire, DISF-Derogatis Interview for Sexual Functioning, FSFI -Female Sexual Function Index, GRISS -Golombok-Rust Inventory of Sexual Satisfaction, ORS- Orgasm Rating Scale,

Differential Diagnosis:

Table 8 shows the salient features of desire, arousal and orgasm to be considered while differentiating FOD from other female sexual dysfunctions and disorders.

Table 8- Differential Diagnosis:

Disorder	Desire	Arousal	Orgasm
Female orgasmic disorder	Normal	Normal	Impaired
Hypoactive sexual desire disorder (HSDD)	Reduced	Reduced	Secondary
Genito-pelvic pain disorder	Variable	Reduced	Secondary
Depression	Reduced	Reduced	Reduced
SSRI dysfunction	Normal	Mildly reduced	Markedly impaired

Management of Female Orgasmic Disorder:

Non-pharmacological management forms the major component of management of FOD. Along with it, pharmacological treatment is given wherever indicated. The *PLISSIT model* is a patient centric model. It involves Permission (Consent), Limited information, Specific suggestions and Intensive Treatment. Treatment of FOD should be planned using this model. (21)

Psychosocial treatment of FOD:

There are a number of psychosocial issues responsible for FOD. They can be societal and family attitude towards sexual pleasures of a female, cultural taboos, life experiences of the woman including sexual abuse and traumatic experiences. Mental illnesses like anxiety and depressive disorder affect the sexual intercourse, so does issues related to self-esteem, body image, negative thoughts about sexual experiences, sexual inhibitions and feelings of embarrassment and shame. Relationship issues like conflicts, dissatisfaction, poor communication, partner sexual dysfunction, differences in interest and desire. Lack of knowledge by either or both partners can affect the sexual relationship negatively. (22)

Psychosocial treatments attempt to deal with these issues.

There are techniques which can be taught to patients to aid in achieving orgasm.

1. **Psychoeducation:** Conducted in early sessions, the psychiatrist/therapist explains how lifestyle factors (diet, exercise, sleep, stress, substance use) influence sexual health. Patients are encouraged to keep a lifestyle journal and set small, achievable goals (e.g., regular sleep schedule, reducing alcohol). It helps to build a foundation of health awareness and normalizes sexual concerns.
2. **Sex education-** Psychiatrist/therapist uses diagrams, models, or reading material to teach female anatomy, clitoral stimulation, and non-intercourse sexual activities. Patients may be asked to identify misconceptions they hold and replace them with accurate knowledge. This helps in reducing shame, increases confidence, and expands the repertoire of pleasurable activities. (23)
3. **Directed Masturbation:** It has a cognitive and behavioral component. It involves a step by step exposure to genital stimulation. It helps through improving attention to sexual cues, making patient feel comfortable with sexual feelings and stimulation. It uses cognitive methods for reducing anxiety and spectating, identifying and challenging unhelpful attitudes and beliefs about sex. It also uses vibrator stimulation and helps in increasing arousal using fantasy or erotic materials. Directed masturbation may be individual, couple or group therapy and individual or group therapy with partner participation. (23)
4. **Systematic desensitization:** This is especially useful for specific anxiety during sexual intercourse. It involves creating a hierarchy of feared experiences and exposure from the least anxiety provoking to the most anxiety provoking experiences till no anxiety or very little anxiety is felt. The hierarchy may include being with the partner and chatting fully clothed, holding hands and hugging, kissing, being undressed by the partner and so on. It can be done in vivo or imaginal. It is known to increase the sexual pleasure and reduce anxiety.
5. **Sensate Focus:** This technique was developed by Masters and Johnson. It is useful in situational FOD in partnered sex. It involves learning to give attention to physical sensations. It begins with touching each other, caressing each other, initially avoiding erotic areas like breasts and genitals; then progressing to touch the genitals and breasts too once the couple is comfortable.

It may be conducted in couple or group therapy. It has been found to be useful in combination with pharmacological interventions. (23)

6. **Coital alignment technique:** Eichel described this technique. This consists of a position during heterosexual intercourse where the man's pelvis stimulates the clitoris during thrusting. This can lead to increased frequency of orgasm in the woman and may lead to simultaneous orgasm. (24)

- 390 7. **Cognitive behaviour therapy:** Psychiatrist/Therapist identifies maladaptive beliefs
391 (e.g., “I shouldn’t enjoy sex”) and replaces them with healthier cognitions. Skills
392 training includes relaxation, communication, and pelvic floor exercises. Homework
393 may involve thought records and behavioral experiments. CBT works on the core
394 beliefs which helps reducing guilt, anxiety, and negative self-perceptions while
395 improving orgasmic satisfaction. (25)
- 396 8. **Couple therapy:** Partners or couples experiencing relationship issues attend sessions
397 together to address communication barriers, intimacy issues, or unresolved conflicts.
398 They are given exercises such as role-playing, communication scripts, and shared
399 homework assignments. All this helps them strengthen relational dynamics and
400 creates a supportive environment for sexual exploration. (26)
- 401 9. **Kegel exercises:** In this, women with FOD learns to contract and relax the
402 pubococcygeal muscles, often using biofeedback devices or vaginal cones. Here daily
403 practice is recommended, with gradual increases in duration and intensity as this helps
404 Improving pelvic floor strength, enhancing arousal and orgasmic intensity. (26)
- 405 10. **Mindfulness and Yoga:** Mindfulness teaches being in present thus for women with
406 FOD practice of mindfulness meditation focused on bodily sensations, often during
407 sexual activity and Yoga postures that enhance pelvic circulation and relaxation are
408 integrated. The two together reduces stress, improves body awareness, and enhances
409 sexual presence. (24) (27)
- 410 11. **Urinary Incontinence Interventions:** Techniques include biofeedback training,
411 vaginal cones, and functional stimulation to strengthen pelvic muscles. Patients track
412 progress and practice exercises daily resulting in restoring confidence and reducing
413 embarrassment, indirectly improving orgasmic function.
- 414 12. **Self help guides:** Patients receive structured manuals with exercises (e.g., sensate
415 focus, masturbation training) to practice independently. Psychiatrist/Therapists review
416 progress during follow-up sessions. It encourages autonomy and reinforces therapy
417 outside clinical settings as well.
- 418 13. **Websites:** Patients are directed to reputable online/offline resources offering
419 educational materials, videos, and intimacy-enhancing tools. Psychiatrist/therapists
420 may assign specific modules as homework. Authentic resources provides discreet,
421 accessible support that also complements the therapy.
- 422 14. **Bibliotherapy:** Patients read selected books or articles on sexual health and therapy
423 techniques. Reflection exercises may be assigned to integrate learning along with
424 Increasing awareness which challenges misconceptions, and reduces isolation. (22)
- 425 Psychosocial treatments for female orgasmic disorder are most effective when applied
426 sequentially: beginning with education and anxiety reduction, progressing to behavioral and
427 relational techniques, and reinforced through self-help and supportive resources. Each
428 technique addresses a specific barrier whether psychological, relational, or physical and
429 together they form a comprehensive therapeutic pathway that restores confidence, intimacy,
430 and orgasmic capacity. Below is a flow chart depicting the order of psychosocial treatment
431 for FOD. The flow chart below summarizes psychosocial treatments.(Fig 3)
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- 433

434 **Fig 3- Psychosocial Treatment of Female Orgasmic Disorder**
435 (Image edited with the help of ChatGPT)

Pharmacological Management of Female Orgasmic Disorder

No single medicine is approved for treating female orgasmic disorder. The response is better for combination of pharmacotherapy with psychosocial interventions. Box 5 gives the objectives of pharmacological management and Table 9 gives the general principles of pharmacological management (28) (29). Table 10 summarizes the medications used for treating FOD.

Box 5 - Objectives of Pharmacological management

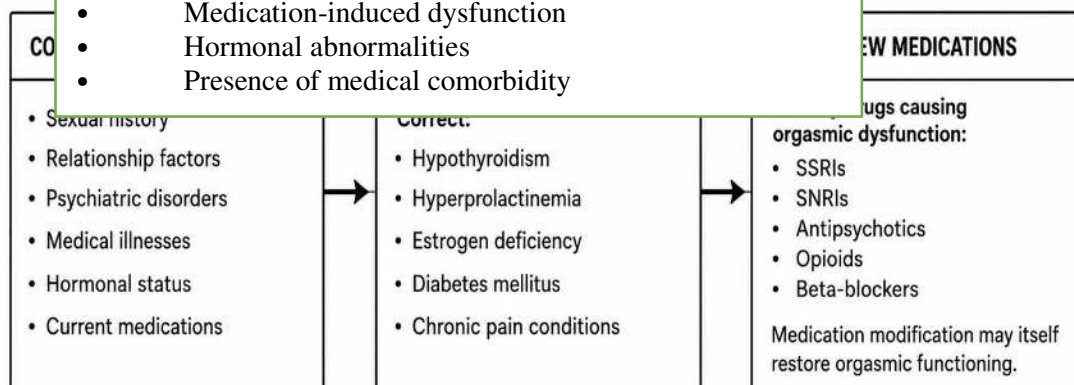
Objectives of pharmacological treatment are:

- Improve orgasm frequency
- Reduce orgasm latency
- Enhance orgasm intensity
- Improve sexual satisfaction
- Treat reversible biological conditions.
- Decrease treatment-emerging sexual dysfunction.

Treatment selection depends upon:

- Lifelong versus acquired disorder
- Generalized versus situational dysfunction
- Presence of psychiatric illness
- Menopausal status
- Medication-induced dysfunction
- Hormonal abnormalities
- Presence of medical comorbidity

Table



The majority of medicines used for treatment of FOD are off label medication and evidence remains limited for them. The treatment selection for FOD should be individualized, according to etiology, menopause status, comorbid psychiatric illness, and concomitant medication use.

Table 10 - Medications used for treatment of FOD

Drug	Mechanism	Typical Dose	Clinical Use
Bupropion	NDRI	150–300 mg/day	SSRI-induced dysfunction, delayed orgasm, anorgasmia, reduced orgasmic intensity, or

			diminished sexual pleasure. (30) (31)
Buspirone	5-HT1A partial agonist	15–60 mg/day	SSRI-induced dysfunction delayed orgasm, anorgasmia, reduced orgasmic intensity, or diminished sexual pleasure(32)
Sildenafil	PDE-5 inhibitor	25–100 mg PRN	Arousal impairment- antidepressant-induced sexual dysfunction, synthetic arousal of the genitalia in diabetes, or vascular-induced decreased genital responsiveness(33)
Testosterone	Androgen replacement	Individualized	Postmenopausal women- indirectly increase orgasmic capacity, strengthen orgasm intensity and overall sexual satisfaction by increasing sexual interest and responsiveness(34)
Estrogen	Hormonal replacement	Individualized	Genitourinary syndrome/Vaginal atrophy- reduces pain, improvement of comfort of intercourse, and enhancing genital sensation(35)
Cabergoline	D2 agonist	0.25–1 mg twice weekly	Hyperprolactinemia mainly due to antipsychotic use(36)

Abbreviations used: SSRI- Selective Serotonin Reuptake Inhibitor, NDRI- Norepinephrine dopamine reuptake inhibitor, 5- HT1A- 5 Hydroxytryptamine 1A, PDE-5 inhibitor- Phosphodiesterase-5 inhibitor, PRN- Pro re nata

Emerging and Experimental Pharmacological Therapies

A. Bremelanotide: Bremelanotide is melanocortin receptor agonist which acts by central enhancement of sexual motivation. This drug is currently approved for Hypoactive sexual desire disorder (HSDD), but has potential future role in orgasmic dysfunction.

B. Oxytocin: Oxytocin act by enhancing Bond and improving orgasmic intensity. Currently very limited evidence is available.

C. Flibanserin: Flibanserin may indirectly improve orgasm through improving the desire and arousal. Currently, it is approved for only Hypoactive sexual desire disorder (HSDD) and not specifically for orgasmic dysfunction.(4)

D. Neuromodulation: Neuromodulation like sacral neuromodulation, posterior tibial nerve stimulation, and pudendal nerve modulation have been shown to be effective, however more evidence is needed for their clinical application.(37)

Special Populations:

There are certain patient populations like those women in menopausal age group, postpartum period, in postoperative period, in malignancies. Women with history of prior trauma also need special consideration and interventions. Table 11 summarizes some points of consideration in these special populations.

Table 11 - Special populations:

1. Menopause	• Oestrogen deficiency and vulvovaginal symptoms. • Reduced genital blood flow and lubrication. • Changes in orgasm intensity or latency. • Individualised use of local or systemic hormone therapy where indicated. • Multifactorial contributors including sleep, mood, and comorbidities.
2. Postpartum	• Perineal trauma or episiotomy. • Breastfeeding-associated hypoestrogenism. • Fatigue, body image, and caregiving demands. • Pelvic floor injury. • Timing of return to sexual activity and counselling.
3. Post-surgical	• Hysterectomy. • Cancer surgery. • Pelvic reconstructive procedures.

	• Effects of nerve injury, altered sensation, body image, and fear of pain
4. Post- traumatic female orgasmic disorder	When there is a history of sexual abuse or a history of witnessing it, there is guilt and shame associated with sexual intercourse. The sensation of pleasure experienced by the woman may also be less or difficult to accept. She may have inhibitions in the mind because of cultural beliefs. The woman may not be able trust her partner, there may be high level of anxiety. Hence, the woman is unable to experience the orgasmic pleasure during intercourse, or even during masturbation. Trauma focused therapy with cognitive and behavioral components, as well as sex education, and if needed pharmacotherapy helps. (38)
5. Malignancy	Vulval and vaginal cancers surgically removed with large excisions can cause nerve injuries and lead to arousal and orgasmic disorders. Breast cancer treatments may lead to body image disturbances thus causing arousal and orgasmic difficulties. Lack of awareness about procedures carried out, about resuming sexual activity and also fear about the same can lead to FOD. Education about the illness, discussion about sexual relations and psychosocial interventions help in dealing with this. (39)

494

495 **Medication induced female orgasmic disorder**

496 Medications prescribed mainly for psychiatric neurological, cardiovascular endocrinology, or
497 chronic pain disorders cause female orgasmic disorder. The causality can be determined by
498 the temporal association, previous normal function, dose dependency and absence of an
499 alternate explanation. A detailed history of symptoms and medications, laboratory
500 investigations like blood glucose, thyroid functions, serum prolactin and serum testosterone,
501 estrogen are to be done. Table 12 summarizes the common medications causing FOD.

Management will include psychoeducation, reducing the dose, switching to another medication and augmentation strategies.

Table 12- Summary of Common Medications Causing Female Orgasmic Dysfunction

Drug Group	Examples	Mechanism
SSRIs	Paroxetine, Fluoxetine	Serotonin excess
SNRIs	Venlafaxine, Duloxetine	Serotonin excess
Antipsychotics	Risperidone, Paliperidone	Dopamine blockade
Mood stabilizers	Lithium, Valproate	Neuroendocrine changes
Benzodiazepines	Lorazepam, Clonazepam	Sedation
Opioids	Morphine, Tramadol	Hypogonadism
OCPs	Combined pills	Reduced free testosterone

Referral for Gynaecological and surgical management:

When the role of gynaecological factors like Endometriosis, Chronic Pelvic Pain Syndromes, Interstitial Cystitis, Vulvodynia, Pelvic Floor Dysfunction, Genitourinary Syndrome of Menopause, Pelvic Surgery, Hysterectomy, Pelvic Floor Repair is determined along with psychosocial factors a gynaecological reference is indicated.

Gynaecological & Surgical management

Orgasmic disorders in women are highly complex and often require a multimodal approach for effective management. This includes addressing the biological, psychological and social causes with medical management, counselling, therapy, pelvic floor therapy, use of sexual aids where applicable as well as modern surgical interventions where indicated.

In younger women, simple difficulties with achieving orgasms are often overcome using the PLISSIT model (21). Sexuality education, sexual aids training, masturbatory exercises and genital exploration with gradual exposure if necessary are effective for both partners. Treat vaginismus and painful intercourse due to poor arousal with appropriate methods and prescribe lubricants where necessary. Educate the partner and address relationship difficulties including domestic violence and fear of unwanted pregnancy.

Post-partum women may need a prescription for pelvic floor exercises; vaginal lubricants and some women may need vaginal estrogen till they start ovulating again. This may be a good opportunity to talk to women about their contraceptive needs.

Dyspareunia and pelvic floor dysfunction may appear in younger women with endometriosis and will need specific treatment in addition to counselling and relationship therapy. Chronic pain management requires a multidisciplinary approach especially if sexual disorders and fertility issues coexist.

Menopause needs careful evaluation and treatment with vaginal estrogen, vaginal moisturisers, appropriate sexual aids, educating the partner and giving permission to enjoy and explore her own sexual needs or preferences. Systemic hormone therapy should be prescribed after careful evaluation and counseling.

Women in perimenopause, menopause and post menopause require a focussed cardiac health awareness and evaluation protocol so they do not get missed. At menopause women often have new or recurrence of old continence related symptoms that need help both surgically and with physiotherapy

Optimise hormonal status where appropriate. Treatment of anemia, thyroid dysfunction, hyperprolactinemia, nutritional deficiencies and optimising Menopause Hormone Therapy may require careful monitoring and review.

Treatment of pelvic organ prolapse and incontinence requires collaboration with medical, surgical and physiotherapy teams as well as gastrointestinal and urology teams in addition to gynaecological treatment. Sexual function and needs often get ignored in the attempt to optimise cosmetic results rather than meet functional needs. Bringing in counsellors and psychosexual therapist into the team ensures that sexual function is not ignored.

Previous surgery like hysterectomy, pelvic reconstructive surgery and extensive dissection can have consequences of postoperative nerve injury, altered anatomy, or scarring which can contribute to orgasmic disorders.

Although newer approaches in cosmetic gynaecology promise restoration of sexual function including orgasms, they still do not have a wide evidence base for recommendation universally. Cases need to be selected carefully to avoid causing harm. It is important to avoid surgery solely to "restore orgasm" without a clear evidence base. Some procedures include - Platelet rich plasma injections to G spot and O spots (O shot), vaginal and vulval rejuvenation, clitoral hood surgery, and use of energy-based devices (40).

Conclusion:

Female orgasmic disorder is multifactorial in origin. Neurobiological and psychosocial factors affect sexual functioning in females of all age groups. It requires a detailed evaluation, history of the presenting problem, coexistence of other sexual dysfunctions, role of cultural factors. A thorough mental status examination and gynaecological examination is necessary for the correct diagnosis and for planning management. Psychosocial management plays an important role even before prescribing medicines. Referral to a gynaecologist at the right time is essential. The consultation liaison between a psychiatrist and a gynaecologist gives better results. Dealing with issues of the partner and also the relationship issues are equally important. An early diagnosis, timely and appropriate management improves the quality of life.

References:

1. Avasthi A, Grover S, Rao TS, editors. Clinical practice guidelines for sexual dysfunctions. *Indian J Psychiatry*. 2017;59(Suppl 1):S91-S115.
2. Meston CM, Hull E, Levin RJ, Sipski M. Disorders of orgasm in women. *The journal of sexual medicine*. 2004 Jul;1(1):66-8.
3. Nahmias LC, Duarte A, Alcina J. Female orgasmic disorder. In *Encyclopaedia of Sexual Psychology and Behaviour* 2023 Mar 9 (pp. 1-7). Cham: Springer International Publishing.
4. Sadock V. A., Normal Human Sexuality and Sexual Dysfunctions, in Boland, R. and Verduin, M.L., Kaplan and Sadock's Comprehensive Text of Psychiatry, Wolters Kluwer Health, 2024
5. Nagendrappa Sachin, Shiva Lakshmi, Desai Geetha, Orgasmic disorders, in Vaishnav, M., Rao, T. S. S., Tripathi, A., & Nebhinani, N. (Eds), *IPS textbook of sexuality and sexual disorders*, 210-221,2022.
6. World Health Organization,2019, International statistical Classification of diseases and related health problems, 11th edition.
7. American Psychiatric Association(2022), Diagnostic and statistical manual of mental disorders, 5th ed, text revised. <https://doi.org/10.1176/appi.books.9780890425787>
8. Nahmias LC, Duarte A, Alcina J. Female orgasmic disorder. In *Encyclopedia of Sexual Psychology and Behavior* 2023 Mar 9 (pp. 1-7). Cham: Springer International Publishing.
9. Rao TS, Darshan MS, Tandon A. An epidemiological study of sexual disorders in south Indian rural population. *Indian journal of psychiatry*. 2015 Apr 1;57(2):150-7.
10. Avasthi A, Kaur R, Prakash O, Banerjee A, Kumar L, Kulhara P. Sexual behavior of married young women: A preliminary study from north India. *Indian Journal of Community Medicine*. 2008 Jul 1;33(3):163-7.
11. Parish SJ, Goldstein AT, Goldstein SW, Goldstein I, Pfaus J, Clayton AH, et al. Toward a more evidence-based nosology and nomenclature for female sexual dysfunctions. *J Sex Med*. 2016;13(12):1888-1906.
12. Kingsberg SA, Althof SE. Female sexual disorders. In: Sadock BJ, Sadock VA, Ruiz P, editors. *Kaplan & Sadock's comprehensive textbook of psychiatry*. 11th ed. Philadelphia (PA): Wolters Kluwer; 2025. p. 2450-2472.
13. Kingsberg SA, Clayton AH, Pfaus JG. The female sexual response: physiology, pathophysiology, and treatment. *J Sex Med*. 2015;12(6):1347-1361.
14. Meston CM, Frohlich PF. The neurobiology of sexual function. *Arch Gen Psychiatry*. 2000;57(11):1012-1020.
15. Georgiadis JR, Kringelbach ML. The human sexual response cycle: brain imaging evidence linking sex to other pleasures. *Prog Neurobiol*. 2012;98(1):49-81.
16. Parish S, Hahn S, Goldstein S The International Society for the Study of Women's Sexual Health Process of Care for the Identification of Sexual Concerns and Problems in Women. *Mayo Clinic Proceedings*, 2019; 94, 842-856
17. Raymond C Rosen. Assessment of female sexual dysfunction: review of validated methods, *Fertility and Sterility*, Volume 77, Supplement 4, 2002, Pages 89-93, ISSN 0015-0282, [https://doi.org/10.1016/S0015-0282\(02\)02966-7](https://doi.org/10.1016/S0015-0282(02)02966-7). (<https://www.sciencedirect.com/science/article/pii/S0015028202029667>)

18. BMJ publishing group, Sexual Dysfunction in Women, 14 July 2026.
<https://bestpractice.bmj.com/topics/en-gb/352>
19. Krakowsky Y, Grober ED. A practical guide to female sexual dysfunction: An evidence-based review for physicians in Canada. *Can Urol Assoc J*. 2018 Jun;12(6):211-216. doi: 10.5489/cuaj.4907. Epub 2018 Feb 23. PMID: 29485038; PMCID: PMC5994984.
20. Grover S, Shouan A. Assessment scales for sexual disorders—a review. *Journal of Psychosexual Health*. 2020 Apr;2(2):121-38.
21. Annon JS. The PLISSIT model: a proposed conceptual scheme for the behavioral treatment of sexual problems. *J Sex Educ Ther*. 1976; 2:1-15.
22. Marchand E. Psychological and behavioral treatment of female orgasmic disorder. *Sexual Medicine Reviews*. 2021 Apr;9(2):194-211.
23. Pope R, Marino J, Myers A, Sahmoud A. Female orgasmic disorder: Current understanding and clinical management. *Obstetrics & Gynecology*. 2026;137(4):745-754.
24. Eichel E. The coital alignment technique: A new approach to female orgasm. *Journal of Sex & Marital Therapy*. 1984;10(2):129-135.
25. Mestre-Bach G, Blycker GR, Potenza MN. Behavioral therapies for treating female sexual dysfunctions. *Journal of Clinical Medicine*. 2022;11(3):567.
26. Masters WH, Johnson VE. *Human Sexual Inadequacy*. Boston (MA): Little, Brown and Company; 1970.
27. Brotto LA, Basson R. Group mindfulness-based therapy significantly improves sexual desire in women. *Behavior Research and Therapy*. 2014;57:43-54.
28. Rao TS, Nagaraj AKM, editors. *IPS textbook of sexuality and sexual medicine*. New Delhi: Jaypee Brothers Medical Publishers; 2023.
29. Clayton AH, Croft HA, Horrigan JP, Wightman DS, Krishen A, Richard NE, et al. Bupropion extended release for antidepressant-associated sexual dysfunction. *J Clin Psychopharmacol*. 2014;34(3):325-331.
30. Modell JG, Katholi CR, Modell JD, DePalma RL. Comparative sexual side effects of bupropion and selective serotonin reuptake inhibitors. *Clin Pharmacol Ther*. 1997;61(4):476-487.
31. Stahl SM. *Stahl's essential psychopharmacology*. 5th ed. Cambridge: Cambridge University Press; 2021.
32. Nurnberg HG, Hensley PL, Heiman JR, Croft HA, Debattista C, Paine S. Sildenafil treatment of antidepressant-associated sexual dysfunction in women. *JAMA*. 2008;300(4):395-404.
33. Parish SJ, Simon JA, Davis SR, Giraldi A, Goldstein I, Goldstein AT, et al. International Society for the Study of Women's Sexual Health clinical practice guideline for systemic testosterone therapy in women. *J Sex Med*. 2021;18(5):849-867.
34. Faubion SS, Larkin LC, Stuenkel CA, Bachmann GA, Chism LA, Kaunitz AM, et al. Management of genitourinary syndrome of menopause. *Mayo Clin Proc*. 2017;92(12):1842-1849.
35. sMelmed S, Casanueva FF, Hoffman AR, Kleinberg DL, Montori VM, Schlechte JA, et al. Diagnosis and treatment of hyperprolactinemia: Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab*. 2011;96(2):273-288.

36. Alsannan B, Banakhar M, Hassouna M. Updates in pelvic neuromodulation: the role of pelvic neuromodulation in pelvic disorders. *Frontiers in Urology*. 2024 Mar 15;4:1329305.
37. Kocsis AL. Female orgasm disorder. An Individual Psychology Approach. *Int. J. Adv. Stud. Sexol*. 2020;2:49-53.
38. Rao TS, Banerjee D, Tandon A, Sawant NS, Jha A, Manohar S, Rao SS. Psychosexual health and sexual medicine in consultation–liaison psychiatry. *Indian Journal of Psychiatry*. 2022 Mar 23;64(Suppl 2):S429.
39. Kaundal A, Kothiwala M. Cosmetic Gynecology. *J Clin Med Surgery*. 2024; 4(1): 1153. <https://jclinmedsurgery.com/articles/jcms-v4-1153.html>
40. Desai SA, Kroumpouzou G, Sadick N. Vaginal rejuvenation: From scalpel to wands. *Int J Womens Dermatol*. 2019 Mar 7;5(2):79-84. doi: 10.1016/j.ijwd.2019.02.003. PMID: 30997377; PMCID: PMC6451893.

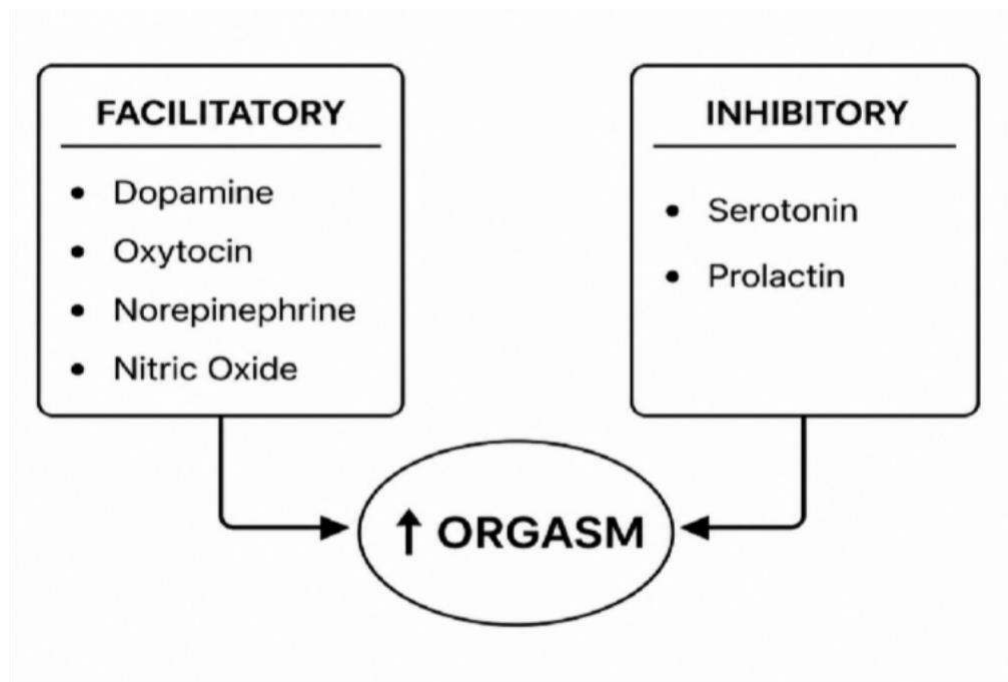


Figure 1: Role of different neurotransmitters

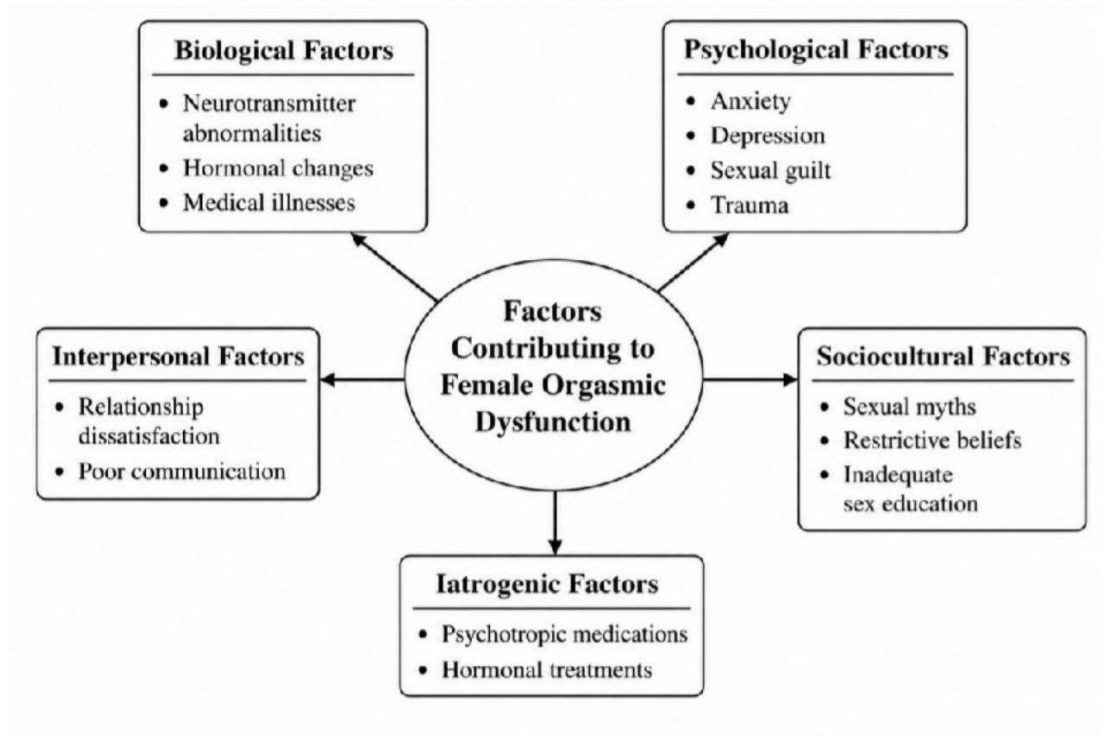


Figure 2- Summary of factors contributing to female orgasmic disorder

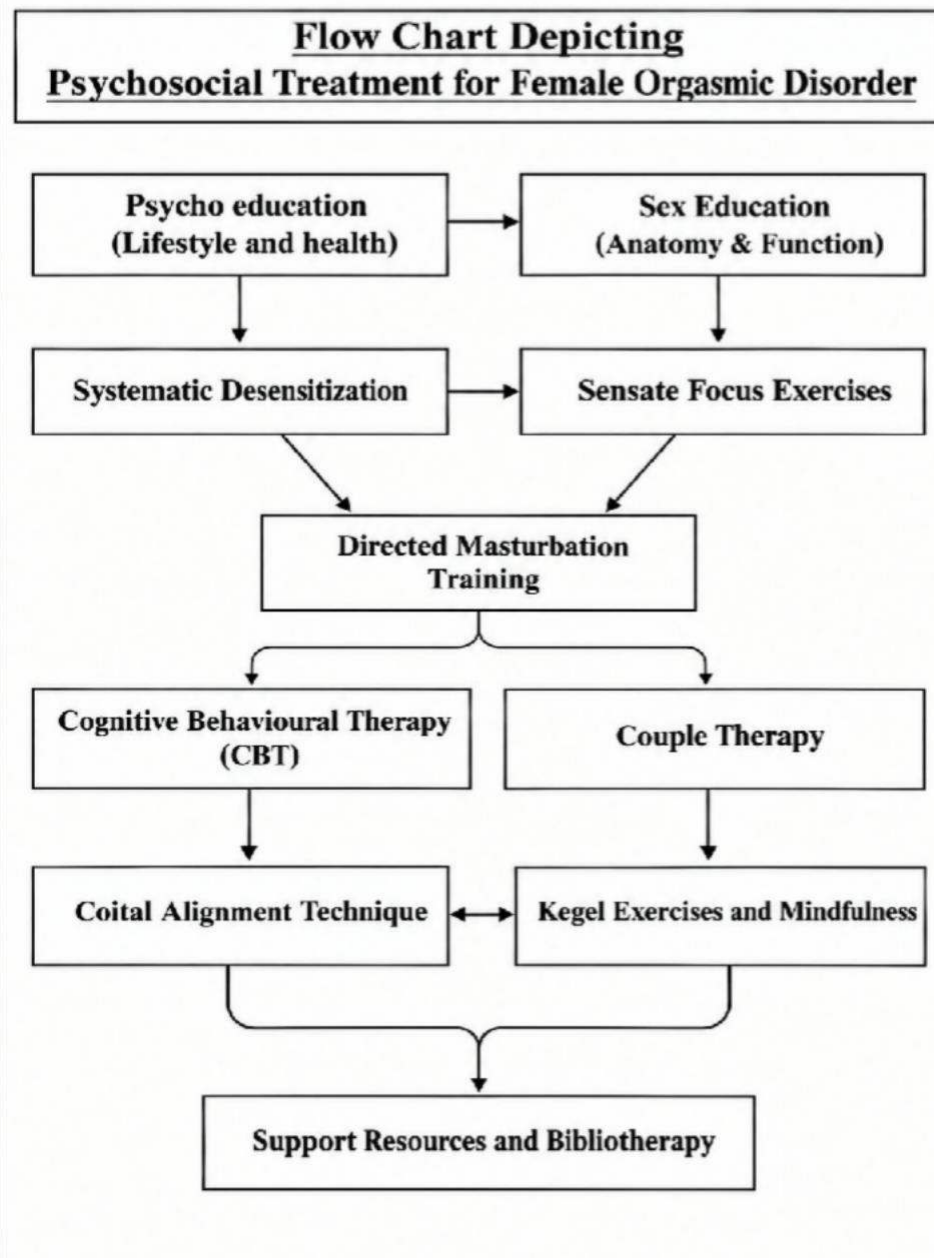


Fig 3- Psychosocial Treatment of Female Orgasmic Disorder
(Image edited with the help of ChatGPT)