PROBLEMS WITH ORGASM

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Introduction

I began my career as a clinical social worker specializing in children and adolescents. After six years I found myself working more frequently with their parents in marital therapy. Curiously, we rarely discussed the couple’s sexual relationship or any sexual problems that might have existed. I either did not think to bring it up or did not know how to do so. In the few instances when the couple brought up sex, I was usually not sure what to suggest that would be helpful. When I decided to return to graduate school for a doctoral degree in psychology, I chose to focus my clinical training on working with couples. I did my internship at the University of Chicago in the Department of Behavioral Medicine, where my primary rotation was in the sex and marital therapy program. For that year, I met with numerous couples, some who presented with sexual problems and some who did not. All of them were asked about their sexual relationship as part of the diagnostic evaluation. In addition, I spent two afternoons each week in the urology clinic asking men of all ages about erectile functioning, orgasm, and sexual desire. Upon completion of my internship year, I stayed for two additional years, one as a postdoctoral fellow and the other as a faculty member.

During these years, I became more comfortable and skilled in asking people about their sexual functioning and concerns. I came to believe that I could be of some help to them. I then joined the faculty in the medical school at Northwestern University, where I later became the director of the sex and marital therapy program. Little did I realize that in my initial effort to get more skilled in working with couples and addressing sexual problems I would be spending a significant portion of my career as a sex therapist. I currently am in private practice and remain on the faculty in the Department of Psychiatry and Behavioral Science. I continue to see individuals and couples for sex therapy and teach students about sexual dysfunction. And, these days, any person or couple I see for therapy can usually expect to be asked about their sexual functioning and relationship, even if it is not the presenting problem. By doing this I am demonstrating my view that this is an important aspect of their lives, and that I am comfortable discussing it if they wish to do so.

I have been asked to write about how to work with women who are experiencing problems with orgasm. For teaching purposes, I have selected three cases that are illustrative of the different types of orgasm problems commonly seen in sex therapy. I begin by briefly summarizing these cases. I return to them throughout the chapter to highlight relevant aspects of evaluation and treatment. I have additionally included brief vignettes of other cases as needed to illustrate my point.
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Case 1: Laura

Laura, age 42, has recently married for the first time. This is her first sexual relationship. She states that she loves her husband, describes him as “the kindest and most wonderful man I’ve ever known,” and worries that she is letting him down because she is unable to orgasm. She states that they are usually sexual once a week and would probably be more so if she could “enjoy herself more.” She reports that she loves to kiss and touch her husband, and loves to be kissed by him, but does not feel very aroused when they have intercourse, and after a few minutes, when “nothing happens,” she tells him to go ahead and orgasm, which he does. She reports that she feels disappointed that “sex does not seem to be as great as I’d heard.” She wonders what is “wrong” with her and hopes that I can help her.

Case 2: Barbara

Barbara, age 36, has been dating a man for the past two years and has been unable to orgasm with him. She was previously married for five years. In her marriage, she had been able to orgasm with her husband until she learned he had cheated on her with her best friend. Her marriage ended. Two years ago, she met her current boyfriend. She describes having a passionate relationship with him and in the initial four months was usually orgasmic with him. It was around this time that her boyfriend revealed that his first marriage ended in divorce because he had cheated on his wife and left her for the other woman. The relationship with the other woman ended three months before he met Barbara. Since his disclosure, Barbara has been unable to orgasm with him. She is able to orgasm with masturbation. She wonders if the similarities between this relationship and her previous marriage are affecting her ability to orgasm with her boyfriend. He has assured her repeatedly that he has been sexually faithful to her.

Case 3: Ellen

Ellen, age 40, has been divorced for ten years. In her first marriage, when she was in her 20s, she remembered sex as infrequent, somewhat boring, and occasionally painful. She did not experience orgasm with her husband or with her two previous college boyfriends. For several years after her divorce, she focused on her career. She had a handful of brief sexual encounters that were only somewhat sexually satisfying and never resulted in orgasm. One year ago, she met a man over the Internet. In the past month, he has moved in with her, and they are contemplating marriage. She reports that sex with him is different from (better than) what it was in her marriage and previous sexual encounters. However, she has been unable to orgasm with any type of sexual stimulation. She is able to orgasm when she masturbates. She wants to know how she can have an orgasm with her partner.

Definition and Diagnostic Terms

The co-authors of the classic book on female orgasm, entitled *Becoming Orgasmic: A Sexual and Personal Growth Program for Women* (Heiman & LoPiccolo, 1988), state that orgasms are usually defined as a combination of both subjective experiences and physiological changes in the vagina and pelvic area. While many descriptions of orgasm exist, a common description is feeling a sense of building tension and then a release, usually accompanied by genital contractions. Women often report a sense of well-being and physical satisfaction following an orgasm.

The DSM-5 (*Diagnostic and Statistical Manual of Mental Disorders*, fifth edition; American Psychiatric Association, 2013) classifies Female Orgasmic Disorder (FOD) as belonging to a group of sexual dysfunctions that are usually characterized by a clinically significant inability to respond sexually or to experience sexual pleasure. The specific criteria for FOD are (1) in almost all (75%–100%)
sexual activity, there is the experience of either (a) markedly delayed, markedly infrequent, or absent orgasms or (b) markedly less intense orgasms; (2) these symptoms have persisted for a minimum duration of approximately six months; (3) the symptoms cause significant distress to the individual; and (4) the dysfunction cannot be better explained by a nonsexual mental disorder, a medical condition, the effects of a drug or medication, or severe relationship distress or other significant stressors.

The DSM-5 states that women exhibit wide variability in the type or intensity of stimulation that triggers orgasm, and those women who experience orgasm through clitoral stimulation but not during intercourse do not meet the diagnostic criteria for FOD. It also distinguishes between lifelong and acquired subtypes (if the orgasm difficulties develop only after a period of normal functioning) and generalized and situational subtypes (if the orgasm difficulties are limited to certain types of stimulation, situations, or partners) and includes a specification for a woman never having experienced an orgasm under any situation (Graham, 2014). Additionally, a diagnosis of FOD cannot be made if inadequate sexual stimulation is the underlying reason.

**Assessing Orgasmic Dysfunction**

**Chief Complaint**

With any patient coming in for help with a sexual concern, the therapist must obtain a description of the chief complaint (e.g., presenting problem). When a woman (or a couple) comes to my office with the chief complaint of anorgasmia, I want to know what she means by this because over the years I have learned that I should assume nothing. In many cases, the woman, or her partner, will report that she is unable to orgasm. However, when I question her further, I may learn that she does orgasm with masturbation and with manual or oral stimulation. What she, or she and her partner, is talking about is that she cannot orgasm during intercourse (which according to the current guidelines of the DSM-5 means she does not meet the criteria for FOD). There have also been times when I have spoken to women who believe they are not having orgasms or are not sure whether they are, but their descriptions of what happens when they are sexual sound like orgasms. In these cases, women have been comparing themselves to what they see in movies, read in magazines, or hear from friends or their partner and conclude that they are not having orgasms because their experience is less dramatic. An example of this is illustrated next:

Jill, age 25, had heard my lecture on female sexuality to her medical school class. She came to my office, stating she was not sure whether she was having orgasms. I asked her what made her think she may not be having them, and she reported that in comparison to what she had seen in the movies and read in magazines, she was more “low-key”; for example, she said, “I don’t yell or lose all sense of control.” She also reported how her best friend told her that when she had an orgasm she “felt outside herself,” would say things she normally would not say, and would get very loud. Jill laughed when telling me this and said she felt “boring” in comparison. She also reported that she always felt aroused during sex and would after a period of time reach what she would consider a peak; this would culminate in a very intense physical sensation accompanied by contractions. This happened when she masturbated as well. Until she had this talk with her friend, she had not really questioned her sexual functioning. Why was she now? This became the focus of further discussion since it appeared to me that anorgasmia was not Jill’s problem.

In addition to obtaining a description of the problem, it is necessary to determine whether the problem is global or situational, and primary or secondary. For example, in the first case example, Laura’s orgasmic disorder is global and primary. She has seldom masturbated in her life. She has always lived with her mother and still does, even after her marriage. She reports she never had much privacy as a child. When she masturbated, she always “kept one ear open for mother to walk in without
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knocking.” Consequently, masturbation was associated with anxiety about being caught rather than feeling pleasure, and Laura does not think she ever had an orgasm. In Laura’s sexual relationship with her husband, she is unable to have an orgasm with manual or oral stimulation or intercourse. While she no longer worries about her mother walking in on her, she now worries about her mother, as well as her mother’s live-in caretaker, hearing her being sexual with her husband.

In Barbara’s case, her anorgasmia is situational and acquired. She can have orgasms when she masturbates and has been orgasmic with partners during intercourse. She was orgasmic with her current partner until he told her of his infidelity. After this, she has been unable to orgasm with any type of sexual stimulation from him.

In the third case example, Ellen’s anorgasmia is situational. She is able to have orgasms with masturbation but not with her partner. This was true in her previous sexual relationships as well. Unlike Barbara, Ellen has not encountered violations of trust in her sexual relationships and views her orgasm difficulties with her partner as a set of skills she wants to learn and a way to enhance her overall sexual pleasure.

Sexual Status Examination

As part of assessing orgasm disorder, I ask the patient or the couple to describe a typical sexual scenario, what Kaplan (1983) referred to as the sexual status examination. Many people are understandably a bit embarrassed or uncomfortable doing this, and I acknowledge that I appreciate how difficult it is to be telling someone they do not know something so private. I explain that it allows me to understand more fully their particular problem as well as what might be contributing to it. During the account, I usually stop the patient or couple to ask more detailed questions (i.e., What were you thinking when this happened? How long do you think you spend kissing before you begin having oral sex or intercourse? How do you let your partner know what you want him or her to do? etc.). Here is an account of Laura’s sexual status examination from the first interview.

Laura: I usually like to have a martini before we begin. It relaxes me. We’ll take our drinks and go into the bedroom. Mother is usually in her bedroom watching TV or already asleep. Victor and I will start kissing and begin to undress each other. We’ll lay on the bed and keep kissing and touching. He gets aroused very quickly.

KMD: What do you mean?
Laura: He’ll get an erection in about five minutes.
KMD: Are you aroused?
Laura: Yes, but not as much as him. We’ll touch some more; Victor mostly touching me.
KMD: Where?
Laura: All over my body.
KMD: Are there any parts of your body you particularly like to be touched?
Laura: Yes, my back, neck, breasts.
KMD: Does he touch your genitals? Is this something you like?
Laura: Yes. He’ll do this until I’m lubricated, and then we start having intercourse. We have intercourse a long time usually, about 10 minutes, so that I can try to have an orgasm, but it never happens. I get tired, and a little sore, and so I tell him to go ahead and have an orgasm. He does but feels bad that I didn’t have one.
KMD: What happens after he has had an orgasm?
Laura: We hold each other, usually fall asleep.
KMD: How are you feeling?
Laura: I feel frustrated that I didn’t have an orgasm. I wonder what’s wrong with me. I don’t want Victor to think he’s done something wrong.
By asking Laura to recount a typical sexual scenario, I get some ideas of other questions to ask and of areas where I may be able to intervene when developing the treatment plan. For example, I wonder whether her husband ever stimulates her manually simply for pleasure rather than doing it until she is lubricated enough for intercourse. I wonder whether they have engaged in oral stimulation and, if so, for how long and under what circumstances. Does she masturbate? Does she fantasize? If yes, what are her fantasies? Given that her mother and the caretaker live in the same house, does she worry they can hear her having sex? What does she think about when she is sexual? Does she ever experience any discomfort or pain and, if so, how frequently does that occur and under what circumstances? Can she tell me more about her need to relax with a martini before a sexual encounter? Is she feeling anxious or stressed about being sexual? I also want to know from Victor what he is thinking. What are his ideas about why Laura is not able to have an orgasm? How does he feel about that? What does he think needs to happen?

I use the sexual status exam throughout the therapy process with the patient as a way of assessing what changes the couple is making and what changes continue to be necessary. It helps me to customize the treatment plan to each individual or couple.

**Sexual History**

In addition to discussing what is happening currently, I am also interested in getting a sexual history from the patient and her partner. This refers not only to the sexual experiences she has had with masturbation and with partners but also to the messages and meanings she has received since childhood about sex and sexuality from her family, religion, and culture. Was sex discussed in her home? If so, how was it discussed? What was discussed? Were there different standards for females and males in the home? How old was she when she had her first sexual experience with a partner? How did she feel about this? How would she describe that experience?

A sexual history also includes asking about unwanted sexual experiences (e.g., molestation, incest, sexual abuse, date rape, stranger rape) and how this was or was not addressed by the patient or by her family. Does the patient believe this has affected her sexual behavior or functioning? If yes, in what way? Many women, based on their sexual histories, end up feeling guilty when they are sexual. Cass (2007), in her book *The Elusive Orgasm*, describes how children, when first discovering their bodies, do not have the language to call what they are feeling sexual. They just know that what they are doing feels good. It is the parent’s attitude or reaction that can set the groundwork for adult guilt. If the parent reacts negatively, the child learns that her feelings of pleasure associated with arousal are wrong or bad. They are something to stop or control. This can greatly impact a woman’s attitude toward her own sexual arousal.

The sexual histories of Laura and Barbara could not be any more different. Laura is the younger of two children and the only daughter of eastern European parents who immigrated to the United States when she was 9 years old. Barbara is the youngest child of three girls who grew up on the East Coast and whose parents are both college educated. Laura reports having an experience when she was about 6 years old of being in a room with several of her cousins and the eldest, a boy of about 12, suggesting they all take off their clothes. She remembers doing so, rather reluctantly. Her aunt discovered the children moments later, and everyone was told to put their clothes on immediately. Laura’s mother punished her by giving her a beating (when asked for more details, she explained she was spanked with a belt). Laura remembers a few times when she would be masturbating in her room and her mother would come in unexpectedly. She thinks her mother suspected that she was masturbating but never actually caught her. Her mother then made a rule that both Laura and her brother had to keep their bedroom doors open. Laura also recalls her mother telling her when she was a teenager that sex was something you had to do with your husband when you were married. She does not remember ever seeing her parents kiss or show affection. Her father was a quiet man.
who worked long hours in a manufacturing company and interacted more with her brother than
he did with her. She was not allowed to date in high school and was allowed to attend college only
if she lived at home (despite having been awarded a scholarship to a four-year university). While she
was in college, her father died in an automobile accident. Laura was expected to remain at home
with her mother and help with the finances. Her brother was already married and the father of two
children.

In contrast to Laura’s sexual history, Barbara remembers her mother telling her about men-
struation and “the basics” about intercourse. She does not recall any other talks, either positive or
negative, about sex. Her parents were affectionate with one another, and she believes they had a
good marriage (her father died of pancreatic cancer rather suddenly four years before the inter-
view). She was allowed to date in high school and did so. She had a boyfriend in her senior year,
and they had sexual contact, although not intercourse. She met her husband-to-be at college, and
they began a sexual relationship that she described as positive and satisfying. Her mother once
made a comment to Barbara about hoping she was using birth control, but that was the extent of
their conversation. She and her boyfriend married while they were in graduate school. She recalls
the first few years as very good sexually. She then learned that her husband was having an affair
with her best friend. Barbara and her husband remained together for almost a year following the
husband’s promise to end the relationship with the other woman. This is when Barbara first had
difficulties with orgasm. However, her husband continued to be unfaithful and eventually left her
for her former best friend.

**Medical/Psychiatric History and Medications**

In assessing any sexual disorder, it is important to ask about any medical conditions, surgeries,
illnesses, and medications that could affect sexual functioning. In addition, you need to inquire about
smoking, alcohol consumption, and recreational drug use. With regard to specifically assessing orgasm
disorders, it is most important to learn what medications the patient is taking. Antidepressants, espe-
cially the selective serotonin reuptake inhibitors (SSRIs) and the selective noradrenergic serotonin
reuptake inhibitors (SNRIs), are widely prescribed to women today. While they can be quite helpful
in treating depression and anxiety, they can also adversely affect orgasm responsiveness. I have spoken
to many women who report they were not made aware of this side effect by their physician or, if they
had, hoped that it would not happen to them. In these cases, lowering the dose or switching to an-
other antidepressant may be indicated. Plus, bupropion (known as Wellbutrin) may be used, either as
an antidote to the SSRI or SNRI or as the sole antidepressant medication. Two new antidepressants,
vilaxodone and vortioxetine, are reported to have far fewer sexual side effects than other serotonin-
drugs. Women who have tried several types of antidepressants and finally found one that worked in
treating their depression or anxiety may not want to change their medication, even if it means not
having an orgasm. For some of them, having an orgasm is not essential for their sexual satisfaction,
and they will focus on other aspects of the sexual interaction they find pleasurable. For others, if
they are open to this, I suggest that they try using a vibrator to see whether this will assist them in
achieving orgasm. In several cases, this has worked for them.

**Treatment**

Sex therapy often involves the combined use of a number of therapeutic techniques, customized
to the needs of particular patients (Plaut & Donahey, 2003). To date, there are no pharmacolog-
cal treatments proven to be successful beyond placebo in treating women with diagnosed FOD
(Meston, Hull, Levin, & Sipski, 2004). The therapeutic techniques would include directed mastur-
bation, sensate focus, sex education and bibliotherapy, communication skills training, use of fantasy
and visualization, vibrators, and Kegel exercises. Some of these treatments are illustrated in the cases introduced in the beginning of this chapter.

Case 1: Treatment: Laura

Although Laura is 42 years old, she reminds me more of my patients who are in their 20s who complain of low sexual arousal and anorgasmia. Please recall that Laura has been married for a little over a year. Her husband was her first sexual partner. She has lived with her mother all of her life. After the death of her father, she finished college and obtained a job with a large accounting firm, where she still works. She met her husband 10 years ago when he came to work at the same firm. They had been friendly with one another from the beginning, but it was not until 3 years ago that he asked her out on a date. Laura reports that she had only been on a few dates in her life. She acknowledges that she had not put much effort into meeting or dating men, even though she had always imagined herself married one day. Her mother was diagnosed with multiple sclerosis when Laura was 27, and it has progressively gotten worse, so that now she is confined to a wheelchair. Laura reports that when she told her mother that Victor had proposed, her mother’s first question was where would she (the mother) live. Victor and Laura decided to have a home built that would accommodate her mother’s disability, allow for a live-in caretaker, and have their bedroom on the second floor.

Laura reports that when she and Victor were dating, it took several months before they had any sexual contact. They would kiss passionately, and she enjoyed this immensely. She told Victor she had never had a sexual relationship and was nervous about moving too fast. He was accommodating to her wishes and stated he had not been surprised to learn this. His own dating and sexual history is not extensive, and his first sexual experience was not until he was 25 years old. Laura and Victor moved on to sexual touching, and she reports she was aroused and enjoyed this. Of note is that while Laura was dating Victor, her mother would comment on how late Laura (who at the time was 39 years old) was getting home and want to know her whereabouts. Laura reports that it was not until after she and Victor were engaged that she stayed overnight at his apartment. She states that she informed her mother that she would not be coming home one particular night, and her mother said, “But you’re not married yet.” She endured her mother’s disapproval the next day and from then on would stay periodically at Victor’s place. Victor was willing to wait until marriage to have intercourse, thinking she would be more comfortable with this. However, Laura stated that she did not want to wait any longer. They had intercourse about four months before they were married. She was disappointed that it was not as pleasurable as she expected it to be. This has continued to be her experience.

Most of the literature recommends directed masturbation as the treatment modality for primary, generalized anorgasmia (Cass, 2007; Heiman & LoPiccolo, 1988; Maurice, 1999; Meston et al., 2004). It is believed that if women can learn how to stimulate themselves to orgasm, they may then be able to teach their partner how to stimulate them to orgasm. Laura was not opposed to doing this but stated she had already tried this, even purchasing a vibrator, and had had no success. We discussed in depth her experience with this, and the following observations were made:

- She was often distracted by the knowledge that other people were in the house (e.g., Victor, her mother, the caretaker) when she masturbated.
- If she waited until everyone was asleep, she was often too tired.
- The vibrator she purchased was too loud, and she worried someone in the house might hear it.
- She felt she had too little time for herself and Victor as it was and said she preferred to be sexual with him rather than masturbating.

In listening to her concerns, and remembering what Laura and Victor had told me in the sexual status exam, I decided to introduce sensate focus exercises. The sensate focus technique was developed
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by Masters and Johnson (1970) in an effort to help partners expand their approach to sexuality while reducing the focus on performance. The partners are asked to take turns touching one another, not specifically to sexually stimulate their partner, but to learn what the other likes and does not like, how they like touching their partner, and how they can communicate constructively with their partner about their likes and dislikes. They are instructed to refrain from intercourse. If you remember, Laura described how Victor would manually stimulate her to get her lubricated, and then they would try intercourse. From that description, it appeared to me that the manual stimulation was a means to an end (e.g., intercourse and hopefully orgasm) and less about simply pleasing. Just because Laura was lubricated did not mean she was necessarily experiencing high arousal. Laura and Victor agreed to try the sensate focus exercise. They returned in two weeks, having done the exercise three times. Laura was extremely enthusiastic. She loved the touching and said that it reminded her of the “earlier days” when they were first dating. She reported that she felt very aroused by the touching and did not want it to stop. In fact, the third time she suggested to Victor that they have intercourse (“I know we broke the rule”) and reports that this was the first time she really enjoyed herself. She said to me, in a somewhat embarrassed tone, “I think I need more touching.” As the session continued, it became clear to me that when Laura and Victor had first added intercourse to their sexual relationship, they cut down on the amount of touching they had previously done because intercourse had become the main focus. This was true as well the few times they engaged in oral stimulation. I suggested they read Sexual Awareness by Barry and Emily McCarthy (1993) as a way of educating themselves about how to enhance their sexual pleasure. I also encouraged them to continue with the sensate focus. As the sessions continued, the sensate focus exercises allowed more genital contact, with the instruction not to engage in intercourse. They did not always follow this, but of note is that when they chose not to follow the instruction, it was always after they had spent a long period of time in genital pleasuring and Laura was the one who initiated intercourse.

In the middle of therapy, Laura had to go away for a few days to a business conference. She decided to use these three nights of privacy in a hotel room to experiment with masturbation. In addition to reading the McCarthys’ book (1993) she had also been reading Heiman and LoPiccolo’s (1988) Becoming Orgasmic. She returned from her trip and to therapy very happy—she had had her first orgasm.

Laura and Victor continued to meet with me in therapy. Their sexual relationship became more enjoyable for both of them and much more varied and interactive. Laura became less apologetic about asking for what she needed sexually to be aroused and more comfortable in seeing herself as a sexual person. This was vividly illustrated when her mother told Laura that she “didn’t want to embarrass” Laura but she could hear Laura and Victor one morning having sex. Laura’s response to her mother was “Turn up the television.” A few months later, Laura experienced her first orgasm with Victor. Both of them were elated. Not only were they happy that Laura could now experience orgasm, but they each felt that the quality of their sexual relationship was overall so much more satisfying.

Case 2: Treatment: Barbara

When working with someone whose orgasm disorder is situational and acquired, the obvious question is what has changed in this individual’s life or circumstances. For Barbara, she first experienced orgasm difficulties after she learned of her husband’s infidelity with her best friend (a double betrayal). When she began dating her boyfriend after her divorce, she had no difficulty experiencing orgasm in her sexual relationship with him. It was only after he confided in her, months after their relationship began, that he had been unfaithful in his previous marriage and left his wife for the other woman that Barbara was unable to orgasm with him. This was further exacerbated when he also told her that he had met with “the other woman” once for dinner for “closure” shortly after he began...
the relationship with Barbara (he had not told Barbara of this at the time it occurred). He swears he has been sexually faithful to her during their two-year relationship, and Barbara states, “I have seen no evidence that tells me he’s lying.” She ruefully acknowledged this is not an endorsement of his honesty.

Barbara can see how her boyfriend’s marital behavior paralleled her ex-husband’s behavior. He also left his wife for the other woman, as Barbara’s ex-husband had, and lived with her for a period of time. In addition, he had not told Barbara about having dinner with her and did so only after Barbara specifically questioned him about whether he had seen the other woman since their relationship ended. While this was close to two years ago, and he swears this was the only time, Barbara finds herself periodically looking for evidence that he is cheating on her. She states that she wants to believe him, and on some level does, but is having difficulty “letting my guard down.” She is insightful enough to realize that this is a metaphor for her anorgasmia. In this case, teaching Barbara to have an orgasm with her partner is not what is indicated. Addressing the breach of trust in the relationship is, as well as dealing with Barbara’s unaddressed feelings regarding her marriage. I recommended that she and her boyfriend get into couples therapy. I also told Barbara that she could benefit from individual therapy as well. In the initial evaluation, Barbara had been surprised to find herself weeping when telling me about her father’s death and how much she still misses him. She also became very emotional when describing the day she learned that the woman her ex-husband was having the affair with was her best friend. Barbara agreed with my recommendations and decided that since she had already met with me and her boyfriend had not, she would meet with me in individual therapy and see another therapist for couple’s therapy with her boyfriend. I referred them to a colleague. Barbara’s feelings of grief and abandonment by father, ex-husband, and former best friend became the focus of her treatment. While her experience with anorgasmia was a nuisance to her, she knew why it existed and hoped that, in time, she would no longer feel the need to “be on guard.”

**Case 3: Treatment: Ellen**

Ellen was referred to me by her gynecologist for help with her situational anorgasmia. She reported that she has always been able to be orgasmic with masturbation but never with a partner. Her sexual history revealed that she was the eldest of three children, was raised Catholic, and had her first sexual encounter with her boyfriend when she was a sophomore in college. Her mother told Ellen and her sister about menstruation, and she suspects her father talked to her brother. She heard about sex from girlfriends. She dated but was not sexually active until college. She has no history of unwanted sexual contact. She married when she was 26 years old. Sex had never been a big part of their relationship, even while dating. She thinks she got married because she felt “it was time.” Many of her friends were marrying, and she had been dating this man for over two years. Neither she nor her husband talked much about their sexual relationship. She states that in hindsight they did not talk much about anything. Four years later, they divorced amicably.

She spent the next decade focusing on her career and is a very accomplished professional in her field. She reports she made little time to date and would have “the occasional one-night stand” if she was traveling on business. None of these times were particularly sexually satisfying to her. She masturbated a few times a month, occasionally with a vibrator, and was usually orgasmic. A friend of hers kept encouraging her to try a popular Internet dating site to meet men. She finally relented and, after meeting a few men who did not interest her, met her current boyfriend. Ellen admits she is surprised at how she feels when she is with him. For the first time in her life, she states she feels like a sexual person. She likes being sexual. Her boyfriend is very caring and is interested in her pleasure, something she had never experienced in her earlier relationships. She states she was surprised when he once asked her what she would like for him to do (“I didn’t know what to say”). Sex had always been what she could do for the other partner.
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In the sexual status exam, what was most noticeable was Ellen’s belief that she was “taking too long” and her worry that her boyfriend would eventually become bored. Consequently, she would tell her boyfriend to stop even when she was really enjoying herself because she was worried about him. It also became clear that she was conflicted about having the attention on her. She liked it yet felt selfish. Her boyfriend assured her that he was not bored, tired, or experiencing her as selfish. He just wanted them to have fun.

Therapy focused on challenging Ellen’s thought processes during sex. She read The Elusive Orgasm by Cass (2007), which helped her to think about her sexual behavior in a new way. Sensate focus exercises were used to help her learn more about what she liked and how to communicate that to her boyfriend. She also had to learn to make time for sex. For the past 10 years, a good deal of her time had been focused on her career. It was not unusual for her to work 50 to 60 hours a week, often willingly. Making time just to be with her boyfriend, let alone making time for sex, was initially challenging for Ellen. However, she was very motivated to make changes. She and her boyfriend recently took their first vacation together, and it was not surprising to me, given how things were going in therapy and between them, that Ellen was orgasmic several times on their trip. She returned happy and pleased. Her remark to me was, “Where were you when I was 20!” She went on to say that she wished had known how “great sex can be” earlier in her life.

Conclusion

This chapter has focused on the different ways that female anorgasmia may present. I selected these particular cases because I felt they were representative of the more common types of orgasm disorders seen frequently and treated successfully in sex therapy. I wanted to demonstrate how treatment, as for any sexual disorder, must take into account the unique characteristics of the person and situation and be tailored accordingly. By introducing you to Laura, Barbara, and Ellen, I hope that you have been able to appreciate the similarities and differences between these three cases. While all three of them presented with orgasm difficulties, you also saw that Laura and Ellen (at age 42 and 40, respectively) were women just coming into their own sexually, despite the difference in their sexual histories. Barbara’s orgasm problem, while situational as was Ellen’s, was directly related to the trust issues in her current relationship, which intersected with her traumatic experience in her previous marriage. In your own work with women presenting with anorgasmia, you will also see a variety of situations in young and middle-aged women. While some may mirror the cases above, it is likely that some of your patients will experience problems with arousal and orgasm as a result of their histories with sexual abuse or assault. Fear of losing control, guilt during sexual arousal, or shame regarding the abuse frequently affect a woman’s ability to orgasm. Your work will necessitate taking into account these factors and tailoring your treatment accordingly. You will also see many older women seeking help for new or acquired anorgasmia due to age or health-related changes. Many women report that, owing to their lowered estrogen levels, their orgasms are less frequent, less intense, and sometimes, for some women, even painful. For many of these women, hormone therapy is helpful and can address some of these concerns. However, for others, hormone therapy is not an option. This can present as a real loss to a woman who has enjoyed a sexually robust life. For others, it presents an opportunity to explore other ways in which they can continue to experience sexual pleasure and satisfaction.

I hope that in writing this chapter I have given you some useful ideas about how to help your patients with this problem. I have attempted to strike a positive and optimistic tone as FOD is frequently responsive to the techniques described in this chapter. Of course, none of these techniques are successful all the time, suggesting that more research and new thinking need to be done in this area. We can and should strive to do better. It is noteworthy that in the last eight years few advances have been made. It is as though research has moved on from the challenges of FOD. One place to begin is challenging our assumptions, moving beyond psychological explanations, and considering
the impact of temperament, culture, and other dimensions yet to be defined (Levine, personal communication, March 2015).

References


Cass, V. (2007). *The elusive orgasm*. New York: Marlow. This is a very pragmatic, helpful book for women to read. It is filled with advice and suggestions on how to overcome the factors that may be preventing orgasm. I have been using this book with many of my patients as an adjunct to therapy.


Maurice, W. (1999). *Sexual medicine in primary care*. St. Louis: Mosby. This is a very helpful, useful book that reviews all the sexual disorders and gives the reader step-by-step instructions as to how to ask the patient about a sexual problem.


Additional Readings and Resources


The websites listed below offer self-help videos, books, vibrators, and erotic films to assist women who are experiencing difficulties with orgasm.

www.bettersex.com
www.goodvibrations.com
www.goodforher.com
www.sinclairinstitute.com