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THERAPEUTIC PRACTICES FOR FEMALE ANORGASMIA – A COGNITIVE-BEHAVIORAL PERSPECTIVE

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anorgasmia
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Summary

Orgasm, as a component of the sexual experience, is a key element of sexual satisfaction in both men and women. Despite this universal function, there is a significant gender disparity in achieving orgasm, generally to the disadvantage of women. Understanding the determinants of orgasm in women is crucial to promoting gender equality in sexuality. Anorgasmia, defined as the absence or delay in the experience of orgasm, is common among women and is a significant health problem that requires special attention and efficacious therapeutic intervention. In the latest ICD-11 classification, difficulties in achieving orgasm are differentiated into both primary and secondary anorgasmia. Cognitive-behavioral therapy (CBT) has demonstrated efficacy in treating anorgasmia through techniques such as directed masturbation, sensation focus, systematic desensitization, sex education, cognitive restructuring and sexual communication training. Additionally, urogynecological physiotherapy has a significant role in the treatment of anorgasmia. The efficacy of these therapeutic modalities can be attributed to enhancements in women's capacity to achieve orgasm, augmented sexual gratification, and diminished anxiety. Enhancing sexual communication within a partner relationship can also facilitate women's ability to reach orgasm with greater frequency. Cognitive-behavioral therapy appears to be an efficacious approach to treating anorgasmia in women. The implementation of these strategies is associated with increased sexual satisfaction and improved quality of sexual life for women.

Introduction

An orgasm is a sudden, involuntary release of sexual tension that may or may not include pelvic floor muscle contractions, intense pleasure, feelings of fulfillment, heightened emotional sensations, increased sensitivity of the genitals, or other noticeable changes usually following high sexual arousal [1, 2]. Both men and women consider the achievement of orgasm to be an important element of sexual satisfaction [3]; however, as studies have shown, men are more likely to achieve orgasm during intercourse than women [4]. It is worth emphasizing, however, that ejaculation and orgasm in men are two separate

physiological processes that may or may not occur simultaneously. Ejaculation is the physiological process of ejaculating one's semen, while orgasm is the subjective experience of intense pleasure.

A significant gender disparity in the experience of orgasm has been found: heterosexual women (65%) and lesbians (86%) experience it less frequently than heterosexual men (95%) [5]. In light of these results, a better understanding of the determinants of orgasm attainment in women is an important step toward efforts to improve gender equality, according to a statement by the World Sexual Health Association [6].

Sexual dysfunction is a health problem, and orgasmic dysfunction is one of the most common sexual complaints reported by women [7]. The literature even indicates that difficulties with orgasm are the second most common form of sexual dysfunction in women, right after difficulties with sexual desire [8]. Precise prevalence rates for orgasmic difficulties are difficult to establish due to the methodological variation used in studies and the variability of diagnostic criteria. In addition, it should be taken into account that only a proportion of women experience significant discomfort associated with the inability to achieve orgasm, making it impossible to meet clinical diagnostic criteria.

Studies show that a higher frequency of female orgasms has positive effects: women who experience them more frequently generally report higher levels of sexual satisfaction and satisfaction with their partner relationship [9]. Moreover, in societies that openly promote and accept women's sexual pleasure, they are more likely to gain knowledge about factors that facilitate orgasm. Additionally, they may be more likely to openly express their sexual experiences, unlike women living in cultural areas where female sexual pleasure is underestimated or even denied, which can lead to significant underreporting of orgasmic achievement rates. In addition, learning sexual assertiveness can help increase the frequency of orgasm attainment and improve sexual satisfaction [10].

The main purpose of this paper is to present therapeutic practices in dealing with anorgasmia in women from the perspective of a cognitive-behavioral perspective.

Understanding anorgasmia in the context of the new ICD-11 classification

Anorgasmia is defined as sustained or recurrent difficulty in failing to achieve orgasm despite adequate sexual stimulation, resulting in an individual's distress [11]. The ICD-10 classification mainly focused on objective measures of sexual satisfaction and defining normative sexual functioning in women. However, according to modern knowledge, sexual satisfaction in women results from the interaction between physical arousal, subjective emotions and psychosocial factors. Thus, it is important to include these elements in modern classification systems [12].

In the ICD-11, orgasmic difficulties are located in the HA02 section and refer to difficulties concerning the subjective experience of orgasm. The ICD-11 category of orgasmic dysfunction is gender-neutral and can be applied to both men and women. According to the

proposed criteria, sexual dysfunction must occur for several months and cause significant suffering. The ICD-11 also uses terms for lifelong and acquired, situational and generalized sexual dysfunctions [13].

As part of the differential diagnosis, primary anorgasmia, the symptom of which is the absence of a history of experiencing orgasm in sexually active women, should be considered. Tension and over-control play a significant role in primary anorgasmia. A high level of neuroticism affects the experience of negative emotions such as fear, stress and anxiety, which affects the ability to relax. In addition, people with perfectionistic personality traits may set exorbitant expectations for themselves and their partner regarding their sex life, which can lead to frustration and pressure [14]. Excessive control of one's own sexual behavior, stemming from internal or external internalized norms and expectations, can lead to sexual inhibitions that make it difficult to achieve orgasm.

The group experiencing secondary anorgasmia includes women who previously achieved orgasm, but lost this ability due to physiological and/or psychological factors. In these situations, they may express internal feelings of inhibition, aversion to their bodies, and manifest resistance to getting close to their partner, perhaps as a result of a traumatic experience or experience of sexual violence [15]. In addition, secondary anorgasmia may be associated with psychological factors, such as unconscious emotions toward the partner, relationship conflicts, and negative family relationship experiences. Existing conflicts or misunderstandings between partners can cause tension and stress and a lack of emotional intimacy.

For women reporting complaints of delayed or absent orgasms, a detailed medical and psychosocial history is necessary [16]. Clinical differentiation is crucial for full understanding and effective application of interventions. The following is an algorithm for the management of anorgasmia in women developed by Lara et al. [17].

Cognitive-behavioral therapeutic work methods

Cognitive-behavioral psychotherapy (CBT) has the potential to help women with sexual dysfunction identify which factors enhance and which inhibit sexual activity, as well as restructure maladaptive thoughts about their sexuality and reduce the tendency to avoid certain sexual behaviors [18, 19]. In the case of female orgasmic disorders, the main goal of CBT is to improve patients' ability to experience orgasm, increase their sexual satisfaction and reduce the high levels of anxiety often associated with this dysfunction. CBT focuses on promoting changes in women's attitudes and behavior through exercises and techniques such as communication skills training, sex education, targeted masturbation, cognitive restructuring, sensation focus and systematic desensitization. Urogynecological physiotherapy is also a complementary component of the therapy. CBT is indicated to have an effective effect on the experience of orgasm [20].

Table 1 describes the goals and effects of cognitive-behavioral therapy for the treatment of orgasmic disorders. In addition, each of the components outlined is discussed below.

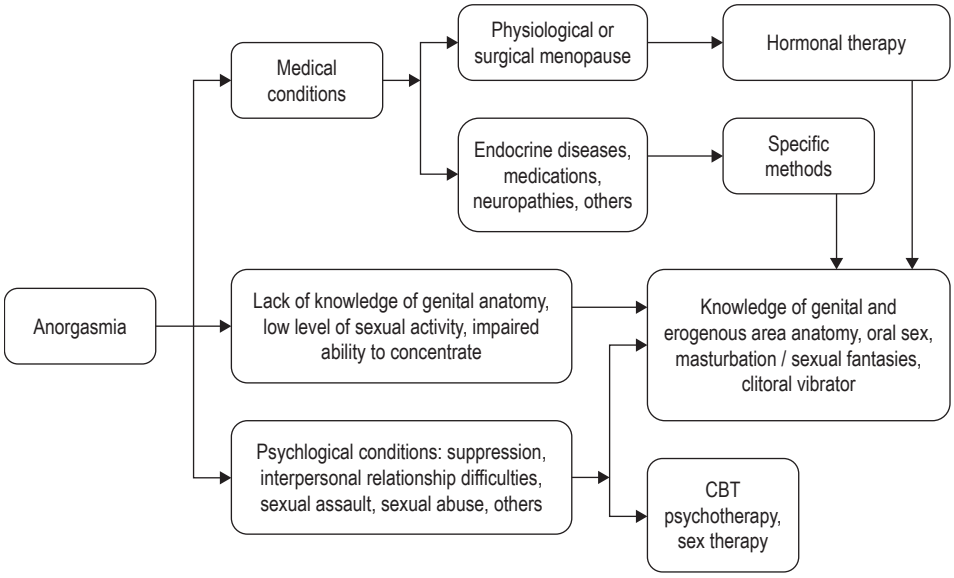

Figure 1. **Intervention strategies for anorgasmia in women – a proposal for a therapeutic algorithm**

Table 1. **Orgasmic disorders in a cognitive-behavioral perspective**

Dysfunction	CBT goals	Therapy components	Effects of CBT
Orgasmic disorders	Supporting changes in attitudes and thinking Reducing anxiety Increasing the ability to achieve orgasm and sexual satisfaction	Directed masturbation Focusing on sensations Systematic desensitization Sex education Cognitive restructuring Communication training Urogynecological physiotherapy	Increased probability of experiencing orgasm during masturbation and/or intercourse.

Directed masturbation

Studies show that the majority of women report orgasm during masturbation [21], which usually involves various types of clitoral stimulation. Therefore, when assessing situational factors associated with experiencing orgasm during sexual intercourse in women, it is important to formulate questions about simultaneous clitoral stimulation. Women reported the frequency of orgasm during intercourse involving simultaneous clitoral stimulation in

51%-60% of cases compared to orgasm in 21%-30% of cases without simultaneous clitoral stimulation. Simultaneous clitoral stimulation and vaginal penetration are associated with a greater likelihood of reaching orgasm [22].

Directed masturbation is a cognitive-behavioral technique, based on mindfulness principles, that involves gradual exposure to genital stimulation to improve awareness of sexual signals. It involves a series of at-home exercises that begin with visual and tactile exploration of the entire body, and moves toward increased genital stimulation with optional use of a vibrator. It aims to reduce anxiety levels and observe, identify and challenge unhelpful attitudes and beliefs about sexuality, while using methods to improve sexual arousal, such as erotic fantasies or pornographic materials [23].

A review study found directed masturbation therapy to be effective, where, depending on the study, 50% to 100% of women with a primary orgasmic disorder achieved orgasm during masturbation and 33% to 85% during sexual intercourse. Results usually persisted or improved at follow-up [24]. When women explore the spheres that give them pleasure, they can adjust their behavior during sexual intercourse, which increases the possibility of achieving orgasm. Studies indicate that women who engage in the practice of masturbation manifest less inhibition and have an increased frequency of reaching orgasm during the sexual act with a partner [25].

Although masturbation and partnered sex have common elements, the factors contributing to the sexual pleasure derived from them differ. Pleasure from masturbation is characterized by a sense of autonomy and control, while sexual experiences with a partner are associated with mutual pleasure, partner satisfaction and closeness [26]. In addition, increased compatibility between masturbation and partner sexual activities may lead to better arousal and less difficulty with orgasm [25].

However, it is worth noting studies that suggest women did not achieve more frequent orgasms by practicing masturbation or experimenting with different partners over the course of their lives. The key to their more frequent orgasms were psychological and relational factors. These factors and abilities included sexual desire, sexual self-esteem and openness of sexual communication with partners, among others. In addition, the ability to concentrate and the partner's appropriate sexual techniques were positive determinants. Relationships in which women experienced emotional well-being were positively associated with achieving orgasms [10]. Importantly, relationship satisfaction and orgasm often act as a two-way feedback loop, with couples who exhibit higher levels of satisfaction more likely to engage in intimate acts that facilitate orgasm, and orgasm facilitates feelings of intimacy and satisfaction [11].

Sensate focus

Sensate focus is an attentional-based behavioral technique designed to reduce anxiety and increase attention to physical sensations during partner activity [27]. It is a method

that focuses on awareness and communication about sensitive sexual areas for each partner. In couples therapy, partners explore non-sexual areas of their bodies while actively refraining from engaging in any sexual activity. The couple can then touch the sexual areas of their bodies without the expectation of sexual intercourse.

According to controlled comparative studies, using sensation focus as an adjunct to directed masturbation is more effective in treating orgasmic disorders than directed masturbation alone [28, 29]. In addition, sensation focus has been tested as part of the treatment of orgasmic disorders, particularly for situational disorders in partner situations [24].

Systematic desensitization

Systematic desensitization is a therapy based on exposure to specific fears. A person suffering from anxiety creates a hierarchy of anxiety situations and exposes themselves to each of these experiences starting with the least stressful ones, progressively moving to more stressful ones until the anxiety experienced disappears or is minimal in situations that previously caused strong anxiety [30].

The hierarchy of anxious sexual experiences can range from less stressful to more challenging, such as dancing with a partner fully clothed, a brief kiss, a prolonged kiss, to more intimate activities such as being undressed by a partner. Systematic desensitization has been tested for reducing anxiety and increasing pleasure and orgasm in sexual situations [31]. However, given its limited efficacy in the treatment of orgasmic disorders, it is discouraged as a primary therapeutic method [23].

Sex education

Sex education is a comprehensive process through which individuals acquire the necessary information and knowledge about various aspects of sexuality and form their attitudes, belief system and values. This process has a significant impact on healthy sexual development, the quality of interpersonal relationships, perception of one's own body, the formation of gender roles and the maintenance of mental health. Inadequate or incorrect information about sexuality increases the risk of sexual disorders [32].

Undoubtedly, psychoeducation plays a key role in the treatment of anorgasmia and should be an integral part of therapeutic work. Education about the structure and physiology of the female genital tract and dispelling sexual myths remains important, focusing on exposing false beliefs and stereotypes that can negatively affect women's sexual and mental health. Moreover, comprehensive sexuality education should be available as part of adult health programs.

Providing adequate knowledge about sexuality and techniques to improve the ability to achieve orgasm can help patients understand and overcome possible obstacles to achieving

a satisfying sex life. Studies, such as those by Jankovich and Miller [33] and Kilmann et al. [34], suggest that even brief sex education sessions can help improve sexual functioning in women with orgasmic disorders.

Reorganization of negative thoughts related to sex

Cognitive-behavioral psychotherapy has a significant effect on regulating an individual's emotions by identifying and analyzing inappropriate behavioral patterns. This method enables the individual to restructure behavior-based thinking, resulting in a more realistic and logical approach to situations, as well as a reduction in negative behavior [35]. Research indicates that four weeks after cognitive-behavioral intervention, a significant increase in mean sexual function scores was observed in the intervention group, suggesting that cognitive-behavioral consultation can have a significant impact on the level of these functions [36]. Also, in terms of sexual assertiveness training, women with anorgasmia reported better functioning after cognitive-behavioral interventions [37].

The ABC model created by Albert Ellis is the model that forms the basis of the work of cognitive-behavioral therapists. It is used to understand a patient's problems, where A stands for activating incident, B for beliefs, and C for consequences, including emotions, physical symptoms and behavior. According to this model, various situations, or activating events, are only an excuse to activate thoughts that reflect a person's more established beliefs about himself, other people or the world and the rules that regulate it [38]. In the case of orgasmic disorders, the model is as follows:

1) Activating event (A): The partner suggests a new technique during sexual activity.
2) Beliefs (B): The woman may think: "I am unable to satisfy my partner," "My sexual needs are strange," "I am not good enough in sex."
3) Consequences (C): These thoughts can lead to feelings of inadequacy, self-doubt and lowered mood, which can further hinder the ability to achieve orgasm and perpetuate the problem of anorgasmia.

According to Barlow [39], people with sexual dysfunction differ from sexually functioning individuals in terms of the affect experienced during sexual activities, showing a greater tendency to experience more negative affect. The type of affective response experienced by individuals in response to sexual stimuli causally influences the focus of attention and pattern of physiological activation by hindering one's own sexual functioning (in the case of negative affect) or supporting it (in the case of positive affect).

The presence of thoughts of failure and the absence of erotic thoughts during sexual activity significantly negatively correlate with the achievement of orgasm in women, while positive thoughts during this activity significantly predict female orgasm [40]. Moreover, a study that focused specifically on orgasmic difficulties in women found that thoughts of sexual abuse (i.e., thoughts of being abused, neglected, or even raped by a sexual partner), thoughts of failure and lack of commitment (i.e., thoughts of inability to achieve

sexual performance and lack of motivation to engage in sexual activity), lack of display of affection by a partner (i.e., thoughts about lack of care and affection from a partner during sexual activity), sexual passivity and control (i.e., thoughts reflecting the idea that women must wait for a man's first step in order not to be seen as reckless and to prevent possible emotional harm), and lack of erotic thoughts significantly indicated difficulties with orgasm in women [41].

Sexual communication training for couples

Communication skills training can have a positive effect on sexual attitudes and may be the preferred therapeutic option to reduce couples' sexual problems [42]. It may be thought that sexual problems impair communication. However, the opposite can also be true – couples who have difficulty talking openly about their concerns, both sexual and non-sexual, may be more likely to experience sexual problems. Either way, it is likely that both sexual dysfunction and sexual satisfaction are directly dependent on communication [43].

Studies have shown that better sexual communication is associated with improved sexual functioning, especially in terms of sexual desire in women. Sexual communication in a relationship, while important in terms of orgasm in both sexes, appears to be of particular importance for women with sexual difficulties [44]. Talking openly about experiences, expectations and concerns can lead to a cooperative search for coping strategies or sexual behavior modifications that can help achieve orgasm. Communication can help normalize the experience of anorgasmia, reducing feelings of isolation and shame associated with the disorder. Emotional support, understanding and a shared search for solutions are key in this aspect.

Available evidence consistently shows that open communication between women and their partners about sexual preferences and difficulties is associated with women achieving orgasms more frequently [45]. Findings suggest that women benefit from both sex therapy and communication-focused therapy. However, some research studies show that when working with couples, sex therapy led to faster results than communication therapy and had better effects on women's self-esteem [46].

The role of urogynecological physiotherapy

Although social and psychological factors play an important role in women's sexual problems, the role of physical factors such as vascular, neurological and muscular factors in women's sexual functioning is unquestionable [47]. A study of the Polish population found that 80% of the subjects knew the location of the pelvic floor muscles, and 73% knew their function. Only half of the women had ever exercised them, most often by inducing contractions. Women who exercised their pelvic floor muscles were more likely to reach orgasm and had higher sexual satisfaction compared to those who did not exercise them

[48]. It is worth noting that exercises under the supervision of a urogynecological physiotherapist are more effective than those performed completely independently by patients at home [49]. Currently, it is recommended that urogynecological physiotherapy be used to evaluate muscle tension and adjust appropriate exercises, as there are situations in which performing these exercises may be contraindicated or require special care. In addition, urogynecological physiotherapy, in conjunction with the treatment of disorders, also has a prophylactic function. This prevention includes, among other things, learning proper toileting habits, proper posture and safe carrying.

Conclusions

Orgasm is an important component of sexual satisfaction in both men and women, but there is a significant gender disparity in its experience during intercourse. The diversity of sexual dysfunctions presents a challenge in establishing treatment protocols. To evaluate the effectiveness of particular techniques, specific studies on individual disorders are needed. Of the various disorders, orgasmic dysfunction and pain disorders are the most extensively studied disorders and those in which sex therapy appears to have the best results [50]. Cognitive-behavioral approaches appear to be a promising approach in dealing with anorgasmia in women. Techniques such as guided masturbation, focusing on sensation, systematic desensitization, sex education, restructuring negative thoughts related to sex, and sexual communication training can be effective therapeutic tools. Studies have shown that these methods lead to improved sexual functioning and increased frequency of reaching orgasm in women.

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