Expanding Pleasure: Moving Beyond Intercourse to Understand Full-Body Intimacy, the Clitoral Network and Female Sexual Anatomy

By Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

BUMS – Hamdard University, Delhi
MD, CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Understanding Female Pleasure Beyond Penetration

One of the most important changes taking place in modern sexual medicine is a move away from defining a woman's sexual experience only by whether vaginal intercourse occurs.

Women sometimes come to me believing that something is wrong with them because penetration alone does not produce strong pleasure or orgasm. Others feel sexually satisfied by affection, external stimulation, emotional intimacy or a combination of experiences but worry that these responses are somehow less “normal” than intercourse.

From a medical perspective, this is an unnecessary source of anxiety.

Female sexual pleasure is produced by a complex interaction among the **brain, clitoris, vulva, vagina, pelvic-floor muscles, sensory nerves, blood vessels, hormones, emotions, relationship context and other sensitive areas of the body**. It cannot be reduced to penetration of the vagina.

The World Health Organization's definition of sexual health specifically includes the possibility of **pleasurable and safe sexual experiences**, together with physical, emotional, mental and social well-being, respect and freedom from coercion. Sexual health is therefore much broader than reproduction or the physical act of intercourse.

This article is therefore slightly different from a traditional “disease” article. **Expanding pleasure is not a disease.** It is an important sexual-health concept that can help women and couples understand normal female anatomy, reduce performance pressure, improve communication and recognize when a genuine medical problem—such as pain, loss of sensation, low arousal or anorgasmia—requires treatment.

Why Intercourse Became the Center of Sexual Expectations

For generations, many couples have received a very narrow message about sexuality:

desire → penetration → orgasm → completion.

If penetration occurred, sex was considered successful.

If it did not occur, or if a woman did not orgasm during intercourse, something was assumed to be wrong.

Modern research shows why this model is incomplete.

The latest international consensus on female sexual dysfunction, published in 2026 following the Fifth International Consultation on Sexual Medicine, specifically states that women vary considerably in the **type and intensity of stimulation required for orgasm**. It also notes that many women require clitoral stimulation and that fewer experience orgasm through vaginal penetration alone. A woman should not be diagnosed with Female Orgasmic Disorder merely because she can orgasm with clitoral stimulation but not through vaginal penetration.

That is a major clinical point.

A woman's body is not malfunctioning simply because penetration is not her most reliable path to pleasure.

Female Pleasure Is Not Located in One Single Place

Another common misunderstanding is that female pleasure should come from one particular structure.

Human sexual pleasure is fundamentally a **brain-and-body experience**.

Touch receptors and sensory nerves transmit information to the spinal cord and brain. The brain then integrates:

physical sensation,

attention,

emotion,

expectation,

memory,

safety,

relationship context,

and sexual meaning.

The latest International Consultation on Sexual Medicine review describes orgasm as a **complex multimodal reflex**, involving sensory genital pathways, spinal mechanisms, brain networks and pelvic-floor activity. It also recognizes that pleasure and orgasm can be influenced by stimulation beyond the genitals in some individuals.

This explains why the same physical touch may feel pleasurable on one occasion and emotionally neutral on another.

The nervous system does not experience touch independently of context.

Understanding the Vulva: More Than the Vagina

When patients say “vagina,” they often mean the entire female genital region.

Medically, this is not accurate.

The **vagina** is the internal muscular canal.

The **vulva** is the external genital region and includes structures such as the labia majora, labia minora, clitoral structures, vestibule and vaginal opening.

This distinction matters because much of the female genital sensory anatomy responsible for pleasure is located **outside or around the vaginal canal**, rather than deep within it.

A comprehensive 2025 anatomical review examined the mons pubis, labia majora, labia minora, vaginal vestibule, clitoris, vestibular bulbs and vagina, concluding that these structures have different anatomical and neurovascular properties that can contribute to arousal, pleasure and orgasm.

Understanding this anatomy is one of the best ways to reduce sexual myths.

The Clitoris: Much More Than the Small Part You Can See

Perhaps the most misunderstood structure in female sexual anatomy is the **clitoris**.

Many people think the clitoris is only the small external structure visible above the vaginal opening.

That visible portion is the **clitoral glans**, but the complete clitoris is substantially larger.

The clitoris includes an external glans and deeper erectile components, including its body and paired **crura**, which extend internally along the pubic region.

Nearby erectile tissues include the **vestibular bulbs**, which are separate anatomical structures but function in close proximity to the clitoral and vulvar tissues during sexual arousal.

Recent anatomical literature continues to emphasize the importance of the clitoris and surrounding vulvovaginal structures in female sexual response. A 2026 clinical review of Female Orgasmic Disorder identifies the clitoris as the principal anatomical structure involved in the female orgasmic response.

So when people refer informally to the **"clitoral network,"** they are often referring to this larger functional system of external and internal clitoral tissues, surrounding erectile structures, sensory nerves and neighboring vulvar anatomy.

Medically, it is more accurate to think of these as **interconnected structures rather than one single hidden organ**.

The Clitoral Glans Is Only the Visible Portion

The externally visible clitoral glans contains dense sensory innervation and plays a major role in pleasure for many women.

But the deeper clitoral body and crura also contain erectile tissue.

During arousal, increased blood flow produces engorgement of clitoral tissues and other genital structures. A 2025 physiological review describes relaxation of smooth muscle in the clitoral erectile tissue, increased blood flow and enlargement of clitoral structures as part of normal arousal.

This means stimulation experienced externally can involve a broader anatomical response internally.

Female sexual arousal therefore should not be imagined as simply "vaginal lubrication."

It involves multiple structures.

What Are the Vestibular Bulbs?

The **vestibular bulbs** are paired erectile structures located alongside the vaginal entrance.

They fill with blood during sexual arousal and contribute to changes in the tissues surrounding the vaginal opening.

They lie anatomically close to parts of the clitoris but should not be described as merely "the internal clitoris." They are distinct structures that function as part of the broader vulvar erectile system.

The 2025 comprehensive anatomical review emphasizes that the vestibular bulbs, clitoris, labia and vaginal structures each have unique anatomical features that may contribute to female arousal and orgasm.

This more accurate understanding replaces older oversimplified ideas of a single pleasure point.

What About the "G-Spot"?

The so-called **G-spot** has been discussed for decades, sometimes as if it were a completely separate anatomical organ.

Modern sexual medicine is more cautious.

Some researchers instead discuss a **clitoral-urethral-vaginal complex**, recognizing that stimulation of the anterior vaginal region may indirectly involve several neighboring tissues, including internal clitoral components, periurethral tissues and other structures.

The 2025 International Consultation on Sexual Medicine basic-science review discusses this broader clitoral-urethral-vaginal complex rather than relying exclusively on the older "G-spot" concept.

Therefore, I tell patients not to become anxious about locating one exact magical point.

Female anatomy is interconnected.

Different women experience sensation differently.

The objective should be **comfort and pleasure**, not passing an anatomical examination.

The Labia Also Participate in Sexual Sensation

The labia are not merely protective structures.

They contain blood vessels and sensory nerves and undergo physical changes during sexual arousal.

A 2025 scoping review of the **labia minora** concluded that these tissues likely contribute importantly to female sexual function, although researchers noted that many aspects of their anatomy, innervation and hormonal responsiveness remain understudied.

This is another reminder that female sexual sensation cannot be reduced to either "clitoris versus vagina."

The vulva is a complex sensory region.

The Vagina Has a Role—But It Is Not the Whole Story

Moving beyond intercourse does not mean that vaginal penetration has no role in pleasure.

Many women enjoy vaginal fullness, movement or deeper stimulation.

Some women can reach orgasm through vaginal or combined stimulation.

Others do not.

All of these patterns can fall within normal variation.

The problem begins when penetration is treated as the **only legitimate sexual activity** or when a woman is expected to reach orgasm from penetration alone despite her own physiology requiring additional stimulation.

The latest ICSM consensus explicitly states that wide variation in the type and intensity of stimulation needed to reach orgasm is normal.

"Clitoral Orgasm" Versus "Vaginal Orgasm": A Misleading Competition

Patients sometimes ask:

"Which orgasm is better—clitoral or vaginal?"

I do not believe this is a clinically useful competition.

The sensory pathways and structures involved in female sexual response overlap.

A woman may experience orgasm primarily through external clitoral stimulation.

Another may prefer combined vaginal and external stimulation.

Another may report pleasure from deeper pelvic stimulation.

The quality of the experience varies among individuals.

A study examining different orgasmic experiences found that subjective intensity can vary depending on the combination of stimulation, but the findings do not support the idea that one type should automatically be considered superior or more mature.

No woman should be told that needing clitoral stimulation makes her sexual response inferior.

Why Clitoral Stimulation Matters So Much

The clinical importance of clitoral stimulation is supported both by anatomy and by contemporary research.

The 2026 ICSM consensus notes that many women require clitoral stimulation for orgasm.

A 2025 experimental study examining women's orgasm expectations found that scenarios incorporating sufficient clitoral stimulation or the woman's most reliable route to orgasm produced substantially greater expectations of orgasm than intercourse-only scenarios.

This does not mean every woman should receive exactly the same stimulation.

It means sexual activity should be **adapted to the woman's actual anatomy and preferences rather than to cultural assumptions**.

Pleasure Does Not Have to End With Orgasm

Another misconception is that sexual pleasure is successful only if orgasm occurs.

Orgasm can be very satisfying, but pleasure is broader.

Women may value:

affection,

emotional closeness,

touch,

arousal,

relaxation,

bodily pleasure,

playfulness,

and connection

even when orgasm does not occur every time.

ACOG specifically notes that difficulty reaching orgasm is common and that some people remain satisfied with closeness and intimacy even when orgasm does not occur.

The important issue is whether the individual herself is satisfied—not whether she meets someone else's expectation.

Full-Body Intimacy: Why the Brain Matters

The largest “sexual organ,” functionally speaking, is not located in the pelvis alone.

The **brain** determines attention, interpretation, emotional safety, anticipation, reward and inhibition.

A person can receive significant genital stimulation while thinking about:

work,

children,

pain,

pregnancy anxiety,

body-image concerns,

an argument,

or performance pressure.

The body may respond poorly because attention is elsewhere.

Conversely, emotional connection, anticipation and sensory touch can increase arousal before the genitals are directly involved.

The current basic-science consensus describes sexual pleasure as involving both “bottom-up” sensory signals and “top-down” brain processes that influence excitation, inhibition and orgasm.

That is why full-body intimacy can be clinically meaningful.

The Skin Is an Important Sensory Organ

Pleasurable touch can occur through many areas of the body.

The neck, scalp, shoulders, back, chest, abdomen, thighs, hands and other areas can acquire erotic meaning depending on the person.

Some individuals experience significant pleasure from breast or nipple stimulation, and the ICSM basic-science review notes that orgasmic responses have even been reported from stimulation of non-genital erogenous regions in some people.

This does not mean every part of the body should feel sexual.

People differ dramatically.

The purpose of expanding pleasure is to **explore what is genuinely comfortable and enjoyable for the individual**, rather than following a universal map.

Full-Body Intimacy Is Not the Same as More Intense Sexual Activity

When I use the phrase **"expanding pleasure,"** I do not mean that couples should constantly seek stronger or more extreme stimulation.

Often the opposite is more helpful.

The goal may be to become more aware of:

comfort,

gentle touch,

warmth,

pressure,

rhythm,

breathing,

emotional closeness,

and bodily sensations.

The broader the definition of intimacy becomes, the less pressure there is for one act—usually intercourse—to carry the entire responsibility for sexual satisfaction.

Non-Penetrative Intimacy Can Be Complete Intimacy

Many couples unconsciously treat non-penetrative sexual activity as merely preparation for intercourse.

That creates a hierarchy:

touch → foreplay → intercourse → orgasm.

Medically, there is no requirement to organize sexual pleasure this way.

Affectionate touch, kissing, massage, external genital stimulation and other mutually desired forms of intimacy can be complete sexual experiences rather than merely preliminary steps.

ACOG explicitly advises people dealing with sexual discomfort or orgasm difficulty to spend more time on stimulation, try a variety of methods and consider sexual activities that do not involve penetration.

This can be particularly important for women with pain, menopause-related dryness or pelvic-floor problems.

Moving Beyond the Word "Foreplay"

I often think the word **foreplay** unintentionally creates a problem.

It implies that everything before penetration is merely preparation for the "real" event.

For many women, the experiences traditionally called foreplay may actually be **the most important components of arousal and orgasm**.

Replacing the idea of "foreplay" with **sexual stimulation, affection or intimacy** can help couples stop rushing toward penetration.

This shift can be especially helpful when a woman requires significant clitoral stimulation before or during intercourse.

Sexual Variety and Satisfaction

A very large 2026 study involving almost 28,000 predominantly female users of a reproductive-health app found that greater variety in **partnered sexual activity** was associated with greater sexual satisfaction and higher orgasm frequency. Clitoral stimulation was among the most commonly reported partnered activities.

This does not prove that variety automatically causes satisfaction; the study was observational.

But it supports an important practical principle:

sexual satisfaction is often broader than penetration alone.

Sexual Devices: Tools Rather Than Replacements for a Partner

Some women benefit from vibratory stimulation because it provides consistent and relatively intense clitoral stimulation.

ACOG includes sexual devices among potential strategies for women who have difficulty reaching orgasm.

A 2025 observational study of sexually active women found partnered use of sexual devices was associated with higher reported arousal, orgasm intensity and sexual satisfaction. Because this was not a randomized trial, it cannot prove cause and effect, but it suggests that devices can be incorporated into healthy partnered sexuality without implying psychopathology.

I explain this to couples because some partners feel threatened by a vibrator.

A device is not a competitor.

It is simply another way of providing stimulation if the woman finds it useful.

Pleasure Should Not Become Another Performance Test

Ironically, teaching people about female pleasure can create a new problem if the message becomes:

“She must now have an orgasm every time.”

That is not healthy either.

The woman may start monitoring herself:

“Am I aroused enough?”

“Why haven't I climaxed?”

“Is my partner disappointed?”

The partner may begin treating orgasm as proof of sexual skill.

This converts pleasure into an examination.

Healthy sexual medicine should reduce pressure, not create a new one.

The goal is:

greater awareness, more options and better communication—not mandatory orgasm.

Communication Is Part of Female Sexual Anatomy in Practice

No anatomical diagram can tell a partner exactly what another person enjoys.

Individual variation is too great.

A partner therefore needs communication.

That may include simple questions such as:

“Is this comfortable?”

“Would you prefer something different?”

“Do you want more time?”

“Do you want to stop?”

The ability to communicate reduces guessing and performance anxiety.

WHO's sexual-health framework emphasizes a positive and respectful approach to sexuality, including safety, pleasure and freedom from coercion.

Communication is therefore not separate from sexual technique.

It is part of good sexual health.

Consent Remains Central to Pleasure

Pleasure cannot be separated from consent.

A physical genital response does not establish desire or permission.

Likewise, a partner should never use ideas about “responsive desire” or “expanding pleasure” to pressure someone into sexual activity they do not want.

Healthy exploration requires:

genuine willingness,

respect,

the ability to change one's mind,

and freedom from guilt or pressure.

WHO specifically includes freedom from coercion and violence within its definition of healthy sexuality.

Responsive Desire: Sometimes Pleasure Comes Before Strong Desire

Many women do not begin every sexual interaction already experiencing intense spontaneous desire.

Sometimes desire is **responsive**.

The woman may initially feel emotionally neutral but willing to be close.

Affection, privacy and stimulation begin.

Arousal develops.

Then sexual desire becomes stronger.

ACOG acknowledges that it can be normal for desire to develop after sexual activity has already begun.

Understanding responsive desire is particularly helpful in long-term relationships.

Waiting indefinitely for a sudden “mood” may reduce intimacy in someone whose desire normally emerges through affectionate contact.

Again, willingness and consent must always be present.

The Connection Between Pleasure and the Pelvic Floor

Female sexual pleasure is also influenced by the **pelvic-floor muscles**.

These muscles surround the pelvic openings and participate in genital sensation and orgasmic contractions.

The ICSM basic-science review describes characteristic pelvic-floor activity as part of orgasm physiology.

A healthy pelvic floor should be able to:

contract,

relax,

and coordinate.

It does not simply need to be "strong."

A woman with excessive pelvic-floor tension may experience painful penetration even when she feels mentally aroused.

A woman with certain forms of weakness or poor coordination may experience sexual sensation differently.

Pelvic-floor physiotherapy can therefore become part of sexual-health treatment when dysfunction is present.

Pain Changes the Entire Sexual Experience

A woman cannot reasonably be expected to explore pleasure while repeatedly anticipating pain.

Conditions such as:

vulvodynia,

pelvic-floor dysfunction,

vaginismus or genito-pelvic pain,

endometriosis,

menopausal vaginal changes,

and other gynecological disorders

can shift the nervous system from pleasure toward protection.

ACOG advises allowing adequate time for arousal, using appropriate lubrication and considering sexual activities without penetration when intercourse is painful, while persistent pain should receive proper medical assessment.

Pain should never simply be pushed through in the name of improving intimacy.

Vaginal Dryness Does Not Mean Lack of Attraction

Another common relationship misunderstanding occurs when a woman experiences little lubrication.

Her partner may assume:

“She is not attracted to me.”

But genital arousal can be affected by:

hormonal changes,

breastfeeding,

menopause,

medication,

stress,

and medical illness.

Subjective desire and genital response do not always match perfectly.

The 2026 ICSM consensus treats cognitive arousal and genital arousal as related but distinct dimensions of female sexual function.

Lubrication is therefore a physiological response—not a perfect measurement of emotional attraction.

Menopause and Expanding Pleasure

Menopause can significantly change the way women experience intimacy.

Lower estrogen may contribute to:

vaginal dryness,

tissue sensitivity,

slower genital arousal,

or discomfort.

Some women continue experiencing normal desire but need longer arousal time, lubrication, treatment of vaginal symptoms or changes in sexual activity.

This can be an ideal time to move away from a rigid penetration-centered sexual script.

Intimacy may become more comfortable when couples emphasize:

affection,

external stimulation,

communication,

adequate arousal,

and activities that do not cause pain.

A sexual life does not have an expiry date.

WHO explicitly recognizes sexual health as relevant throughout life, not only during reproductive years.

Pregnancy and the Postpartum Period

Pregnancy and childbirth can also change sexual response.

After delivery, women may experience:

fatigue,

sleep deprivation,

breastfeeding-related hormonal changes,

vaginal dryness,

pelvic-floor symptoms,

healing tissues,

and body-image changes.

Under these circumstances, insisting that sexuality return immediately to penetrative intercourse can create anxiety and pain.

Expanding the definition of intimacy can help couples gradually restore sexual connection while the woman's body recovers.

If persistent pain, significant pelvic-floor symptoms or other postpartum problems are present, they should be medically evaluated.

Aging Does Not Eliminate the Capacity for Pleasure

Older adults sometimes believe sexual pleasure is something they should simply abandon.

Modern sexual-health thinking rejects this assumption.

Sexuality can remain meaningful throughout life, although its expression may change.

Aging may alter:

arousal speed,

lubrication,

erection,

energy,

medical conditions,

and medication use.

But intimacy can adapt.

Expanding pleasure away from rigid performance goals can be especially useful as couples age.

WHO emphasizes that sexual health and well-being remain relevant across the life course.

Infertility Can Make Sexuality Too Goal-Oriented

This issue is particularly important in my work at Saira Health Care.

Couples experiencing infertility often begin their journey with a normal sexual relationship.

Then everything becomes connected to pregnancy.

“Is today ovulation day?”

“We must have intercourse tonight.”

“Do not miss the fertile window.”

Intercourse gradually becomes a fertility procedure.

Pleasure becomes secondary.

The woman may focus on conception rather than arousal.

The man may develop performance anxiety.

This can damage the couple's sexual relationship even though neither partner has lost attraction.

When I counsel infertility patients, I therefore encourage couples to preserve some intimacy that is **not purely reproductive**.

Sexual health and fertility health are connected but are not identical.

Female Pleasure and Fertility Are Different Concepts

A woman does **not** need to experience orgasm for fertilization to occur.

Pregnancy can occur without female orgasm.

However, sexual pain, severe low desire, inability to tolerate penetration or relationship distress can indirectly make natural conception more difficult because intercourse may become infrequent or impossible.

This is why infertility treatment should sometimes include sexual-health assessment.

A couple should not be told simply to “keep trying” if every attempt at intercourse is painful or distressing.

The “Orgasm Gap” and Why Sexual Scripts Matter

Researchers often use the term **orgasm gap** to describe differences in orgasm frequency that occur across particular partnered sexual contexts.

One explanation is not simply anatomy but also **sexual scripts**—the expectations couples bring into intimate situations.

The 2025 experimental study mentioned earlier showed that when partnered sexual scenarios explicitly included adequate clitoral stimulation, women's expected likelihood of orgasm increased substantially compared with intercourse-only scenarios.

This suggests that at least part of the problem may be cultural:

If intercourse is treated as the center of sex, the woman's most reliable route to orgasm may receive inadequate attention.

Changing the script can therefore change expectations and potentially experience.

What If a Woman Has Never Had an Orgasm?

If a woman has never experienced orgasm and is distressed by this, the condition may fall within **lifelong Female Orgasmic Disorder**, depending on clinical assessment.

But the latest 2026 consensus emphasizes that adequate stimulation must be considered before diagnosing a disorder. A woman who can orgasm with clitoral stimulation but not vaginal penetration should not automatically be diagnosed with FOD.

Treatment may include:

accurate sexual education,

learning what stimulation works,

reducing shame,

addressing anxiety,

sex therapy,

mindfulness,

pelvic-floor assessment,

or treatment of an underlying medical condition.

There is no universal “orgasm medicine.”

Psychological Therapies Can Improve Sexual Function

Sexual pleasure is not purely mechanical.

A 2026 network meta-analysis involving 45 studies and more than 4,700 women found that **sex education, cognitive behavioral therapy, mindfulness-based interventions, PLISSIT-based counseling and general sexual counseling** improved measures of female sexual function compared with usual care or controls.

A separate 2026 systematic review and meta-analysis found mindfulness-based CBT improved desire, arousal and orgasm outcomes in women with sexual dysfunction without pain conditions.

This does not mean that female sexual problems are “all psychological.”

It means that brain, body and relationship factors are inseparable in sexual function.

When Expanding Pleasure Is Not Enough

Education and experimentation are useful only when there is no untreated medical problem interfering with sexual response.

Professional assessment is appropriate when a woman experiences a persistent or distressing loss of desire or arousal, complete inability to orgasm despite adequate stimulation, major genital numbness, painful intercourse, unexplained bleeding, severe vaginal dryness, pelvic pain, sudden sexual-function changes after surgery or medication, or significant relationship distress related to sexuality.

The latest 2026 review of female sexual dysfunction emphasizes that different disorders—desire, arousal, orgasmic and pain disorders—require different treatments and often benefit from a multidisciplinary approach.

Female Pleasure Is Not One Diagnosis

This is why I avoid the phrase:

“She has female sexual weakness.”

That label tells us almost nothing.

A woman might actually have:

low desire,

responsive desire,

arousal disorder,

anorgasmia,

pelvic-floor dysfunction,

vulvodynia,

menopause-related dryness,

medication-associated dysfunction,

or no disorder at all.

Good sexual medicine identifies the specific issue before treatment.

The Role of Unani Medicine in Expanding Sexual Well-Being

As a Unani physician, I believe one of the great strengths of the Unani system is its emphasis on the **whole person**.

Sexual health does not exist separately from:

sleep,

nutrition,

physical health,

mental state,

energy,

relationships,

digestion,

and chronic illness.

However, I also believe modern Unani practice must distinguish between traditional concepts and evidence that has been demonstrated in contemporary clinical trials.

There is **no high-quality evidence showing that one particular Unani formulation can universally expand sexual pleasure or guarantee orgasm**.

For this reason, I use Unani medicine most responsibly as part of an **integrative framework**, particularly through lifestyle regulation, individualized general-health support and treatment of associated problems.

Asbab Sitta Daruriyya: The Six Essential Factors

Classical Unani medicine describes **Asbab Sitta Daruriyya**, the six essential determinants of health.

CCRUM defines these as:

air,

food and drink,

physical movement and rest,

mental activity and peace,

retention and evacuation,

and sleep and wakefulness.

These principles may appear traditional, but their practical relevance to sexual health is easy to understand.

A woman who is:

severely sleep-deprived,

chronically stressed,

physically unwell,

constipated and uncomfortable,

sedentary,

or metabolically unhealthy

may understandably have less capacity to experience relaxed sexual pleasure.

Correcting these factors does not automatically produce orgasm.

But it creates a healthier physical and psychological environment in which sexual response can function.

Harakat-o-Sukun Badani: Movement and Rest

Unani medicine places importance on an appropriate balance between physical movement and rest.

CCRUM identifies **Harakat-o-Sukun Badani** as one of the essential health factors.

From a contemporary perspective, appropriate physical activity can support:

cardiovascular health,

energy,

body confidence,

sleep,

metabolic health,

and mental well-being.

All of these can indirectly support sexual health.

The objective is not extreme exercise.

The objective is overall vitality.

Harakat-o-Sukun Nafsani: Mental Activity and Peace

Unani medicine also recognizes **mental activity and peace** as an essential component of health.

CCRUM specifically describes peace of mind as important alongside mental activity.

This fits very naturally with contemporary sexual medicine.

A woman who is mentally overwhelmed cannot simply switch sexual arousal on by command.

Anxiety, fear, shame, relationship conflict and performance pressure may all inhibit pleasure.

This is one area in which Unani whole-person care and modern biopsychosocial medicine are especially compatible.

Ilaj-bil-Tadbir: Regimental and Lifestyle Therapy

CCRUM describes **Ilaj-bil-Tadbir**, or regimental therapy, as one of the principal treatment approaches in Unani medicine, together with dietotherapy and pharmacotherapy.

For sexual well-being, the most relevant supportive measures may include:

regular physical activity,

appropriate rest,

improved sleep,

stress management,

healthy daily routine,

and correction of general lifestyle problems.

These should complement—not replace—sexual education, medical treatment or psychological therapy when those are needed.

Ilaj-bil-Ghiza: Dietotherapy

There is no scientifically established “orgasm food.”

A healthy diet should be used to support:

energy,

cardiovascular health,

healthy body weight,

diabetes control,

and general nutritional status.

These factors can influence sexual health indirectly.

I discourage exaggerated claims that one dry fruit, herb, spice or food will transform female sexual pleasure immediately.

Sexual response is too complex for such promises.

Ilaj Nafsani: Psychological and Emotional Care

CCRUM's official terminology recognizes psychological treatment within the wider Unani therapeutic framework.

This is especially relevant to sexual health.

A woman may need support for:

sexual guilt,

anxiety,

relationship conflict,

body-image concerns,

fear of pain,

or infertility-related pressure.

In such situations, appropriate counseling or psychosexual therapy may be more useful than additional medicine.

What About Unani Aphrodisiac Medicines?

Classical Unani texts and CCRUM publications contain formulations traditionally described as **Muqawwi-e-Bah**, or aphrodisiac/sexual-strengthening preparations.

However, traditional use should not be confused with proof that these formulations treat all modern female sexual concerns.

If a woman has:

vulvodynia,

pelvic-floor hypertonicity,

menopause-related pain,

SSRI-induced anorgasmia,

or insufficient sexual stimulation,

an aphrodisiac alone may completely miss the actual problem.

I therefore believe the patient's specific diagnosis should come before pharmacotherapy.

Avoid Applying Unverified Products to Vulvar or Vaginal Tissue

Another important warning is that “natural” does not automatically mean suitable for genital tissue.

Strong oils, irritant herbs, perfumes, concentrated extracts or homemade preparations can cause:

burning,

allergic reactions,

or contact dermatitis.

Women with vulvodynia, dryness or sensitive genital skin may become substantially worse after using such products.

Any topical treatment should therefore be appropriate for vulvar or vaginal use and selected according to the underlying condition.

Dr. Nizamuddin Qasmi's Specialized Approach to Female Sexual Pleasure

At **Saira Health Care**, I approach female sexual-health concerns by first asking a fundamental question:

Is the patient experiencing a normal variation—or a genuine dysfunction?

Then I try to identify which component requires attention.

Is desire present?

Does desire develop responsively?

Is mental arousal present?

Is genital arousal adequate?

Is there lubrication?

Is clitoral sensation normal?

Is orgasm possible?

Is there pain?

Is the pelvic floor functioning normally?

Has childbirth, menopause, medication or illness changed sexual response?

Is infertility treatment creating pressure?

Is the couple communicating?

This prevents us from treating every concern as “sexual weakness.”

A Practical Integrative Approach at Saira Health Care

My preferred management approach has several stages.

First, I provide accurate education about female anatomy, because many problems begin with misinformation.

Second, I identify whether intercourse-centered expectations are creating unnecessary pressure.

Third, I investigate possible medical barriers, including pain, hormonal changes, pelvic-floor dysfunction, chronic illness and medication effects.

Fourth, I assess psychological and relationship contributors.

Fifth, where appropriate, I recommend evidence-based interventions such as sexual counseling, CBT or mindfulness, pelvic-floor physiotherapy, gynecological treatment or other specialist care.

Finally, Unani principles may be incorporated to support general health, sleep, nutrition, physical activity, emotional balance and associated conditions.

That is what I mean by **integrative sexual healthcare**.

The Contribution of Saira Health Care to Sexual Disorders and Infertility

At Saira Health Care, our focused work in sexual disorders and infertility has repeatedly shown that reproductive health and sexual pleasure should not be treated as completely separate subjects.

Couples may come to us for:

infertility,

low libido,

painful intercourse,

anorgasmia,

vaginismus,

vulvodynia,

pelvic-floor problems,

erectile dysfunction,

or performance anxiety.

Behind the initial complaint there may be a broader sexual-health issue.

For example, a woman may say:

“I never orgasm.”

The actual issue may be that intercourse has always been the only form of stimulation attempted.

Another woman may say:

“I have lost interest in sex.”

The real issue may be painful penetration.

Another may have good desire but insufficient lubrication because of menopause.

Another couple may have turned intercourse into a timed fertility procedure and lost the emotional side of intimacy.

Our responsibility is to identify the real problem rather than prescribe one generic sexual medicine.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi is the **Founder & Chief Physician of Saira Health Care**, with a focused practice in **Sexual Disorders & Infertility**.

His professional qualifications and training include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

My approach combines my background in Unani medicine with contemporary sexual and reproductive-health knowledge.

The objective is not to promote unrealistic ideas of instant sexual performance.

The objective is to help patients understand their bodies, identify genuine health problems, communicate better and experience intimacy in a way that is **comfortable, consensual and personally satisfying**.

Common Myths About Female Pleasure

“Intercourse is the main form of sex, and everything else is only preparation.”

Not medically.

For many women, external clitoral stimulation is central to sexual pleasure and orgasm. Non-penetrative intimacy can also be a complete and satisfying sexual experience.

“A normal woman should orgasm from vaginal penetration.”

Incorrect.

The latest international consensus explicitly recognizes that many women require clitoral stimulation and that inability to orgasm from vaginal penetration alone does not automatically constitute Female Orgasmic Disorder.

“The clitoris is just the small visible button.”

Incorrect.

The visible glans is only one portion of a larger erectile structure that includes a body and internal crura. Nearby vestibular bulbs and other vulvar tissues also participate in genital arousal.

“Clitoral orgasms are less mature than vaginal orgasms.”

There is no sound medical reason to rank female orgasms in this manner.

Women experience pleasure through different combinations of sensory stimulation.

“If she needs a vibrator, her partner has failed.”

No.

A vibrator is simply a method of providing stimulation. ACOG recognizes sexual devices as one option for women who have difficulty reaching orgasm.

“If she does not orgasm, sex was unsuccessful.”

Not necessarily.

Some women value arousal, intimacy and pleasure even without orgasm. The woman's own satisfaction matters more than an externally imposed goal.

“More intense stimulation is always better.”

No.

Sensitivity varies substantially. Some women prefer gentler or indirect stimulation.

Comfort and individual preference should guide the experience.

“Good partners should automatically know what the other person likes.”

No.

Individual preferences cannot be reliably guessed. Communication is part of healthy sexuality.

Does Every Woman Need to Explore Full-Body Pleasure?

No.

This is an opportunity, not an obligation.

Some women are completely satisfied with their existing intimate life.

If the woman and her partner are comfortable, consensual and satisfied, there is no medical requirement to change anything.

Sexual medicine should never turn exploration itself into another performance standard.

Can Full-Body Intimacy Help Women Who Have Difficulty Reaching Orgasm?

Sometimes.

Reducing the exclusive focus on penetration may allow more time for the types of stimulation the woman actually needs.

Sexual education, changing stimulation patterns, mindfulness-based CBT and counseling all have evidence in selected women with female sexual dysfunction.

But persistent anorgasmia should still be assessed when it causes distress.

Can Expanding Pleasure Improve Low Libido?

Sometimes indirectly.

If previous sexual experiences have been rushed, uncomfortable or unrewarding, desire may understandably decrease.

Increasing communication, improving stimulation and removing performance pressure may make intimacy more rewarding.

However, true persistent low libido can also result from medical conditions, medication, depression, hormonal factors or relationship problems and may need separate assessment.

Does Female Pleasure Affect Fertility?

Pleasure or orgasm is not required for conception.

However, painful, stressful or unsatisfying sexual experiences may reduce frequency of intercourse, create performance anxiety and complicate attempts at conception.

Sexual health should therefore be protected during infertility treatment.

Should Couples Always Try to Produce Female Orgasm?

No.

Female orgasm should be available as a valued possibility, not imposed as a performance requirement.

The healthiest objective is mutual pleasure and satisfaction.

Orgasm may be important to one woman and relatively less important to another.

Can Sexual Education Really Improve Female Sexual Function?

Yes, for many people.

The 2026 network meta-analysis of psychological approaches found that **sex education and sexual counseling**, along with CBT and mindfulness-based interventions, improved overall female sexual-function measures compared with control care.

This reinforces something I frequently see clinically:

Accurate information can itself be therapeutic.

When Should a Woman Seek Professional Assessment?

Most variations in sexual preference do not require medical treatment.

However, seek professional assessment when there is persistent or distressing absence of sexual desire, inability to become aroused, inability to orgasm despite adequate stimulation, significant genital numbness, persistent vaginal dryness, painful intercourse, vulvar burning, pelvic pain, involuntary pelvic-floor tightening, unexplained bleeding, major sexual changes after surgery or medication, or sexual difficulties seriously affecting the relationship.

These symptoms may represent conditions that deserve individualized medical, gynecological, psychological or pelvic-floor treatment. The latest female-sexual-dysfunction literature strongly supports diagnosis according to the specific subtype rather than treating all sexual concerns in the same way.

My Message to Women and Couples

When I speak with couples about female sexual pleasure, I want them to understand one principle above all:

Intercourse is one form of intimacy. It is not the entire definition of sexuality.

The female body contains a rich network of sensory and erectile structures.

The clitoris is much larger than its visible tip.

The vulva contains multiple sensitive tissues.

The pelvic floor participates in sexual response.

The vagina can provide pleasurable sensations for many women.

The breasts, skin and other areas can also contribute.

And above all, the **brain gives meaning to every one of these sensations**.

Some women primarily enjoy clitoral stimulation.

Some enjoy penetration.

Many prefer a combination.

Some need considerable time to become aroused.

Some experience responsive rather than spontaneous desire.

Some value orgasm greatly.

Others value affection and connection just as much.

None of these differences makes a woman less feminine or less sexually healthy.

The problem begins when a woman feels she must experience pleasure in one predetermined way.

Modern sexual medicine increasingly recognizes that female sexual function is **individual, multidimensional and context-dependent**. The newest international consensus explicitly acknowledges wide variation in stimulation requirements and rejects the idea that inability to orgasm from penetration alone automatically represents dysfunction.

At **Saira Health Care**, my aim is to bring that modern understanding together with the holistic strengths of Unani medicine.

We look not only at the genital organs but also at:

general health,

sleep,

nutrition,

physical activity,

pelvic-floor function,

psychological well-being,

relationship quality,

medications,

hormonal changes,

and reproductive goals.

When necessary, we combine sexual education with appropriate medical care, pelvic-floor rehabilitation, counseling or other specialist support.

Because sexual health is not simply the absence of disease.

As WHO emphasizes, it also includes the possibility of **safe, pleasurable and respectful sexual experiences**.

For many women and couples, expanding pleasure begins with a simple change in perspective:

Stop asking only, "Did intercourse happen?"

Instead ask:

"Was this comfortable?"

"Was it consensual?"

"Did we feel connected?"

"Did we understand what the body actually enjoys?"

“Was pleasure allowed to take more than one form?”

That is not merely a different approach to sex.

It is a healthier and more scientifically accurate understanding of female sexual well-being.

Medical Disclaimer

This article is intended for general sexual-health education and does not replace individualized medical advice, gynecological assessment, psychosexual counseling or treatment. Variation in preferred sexual activity and the need for clitoral stimulation are generally normal. Persistent sexual pain, major loss of sensation, inability to become aroused, distressing anorgasmia, unexplained genital bleeding or other significant changes should be evaluated by an appropriately qualified healthcare professional. Unani medicines should be individualized and should not be presented as guaranteed treatments for sexual pleasure or orgasmic difficulties. All sexual activity must remain voluntary, mutually consensual and free from pressure or coercion.