Anorgasmia in Women: Understanding Lifelong or Acquired Difficulty Reaching Orgasm

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 a Common but Frequently Unspoken Sexual-Health Concern

One of the most private questions a woman may bring to a sexual-health consultation is:

"Doctor, I have never experienced an orgasm. Is something wrong with me?"

Another woman may tell me:

"I used to reach orgasm normally, but for the past year I simply cannot."

A third patient may experience orgasm during self-stimulation but not during partnered sexual activity and may believe this means there is a serious physical problem.

These situations are related, but they are not necessarily the same condition.

The term **anorgasmia** usually refers specifically to an inability to experience orgasm. The broader modern medical term **Female Orgasmic Disorder (FOD)** also includes orgasms that are markedly delayed, unusually infrequent, significantly reduced in intensity or lacking the expected sense of pleasure.

The latest international consensus from the Fifth International Consultation on Sexual Medicine, published in 2026, defines Female Orgasmic Disorder as a **persistent or recurrent and distressing problem involving orgasm frequency, intensity, timing or pleasure for at least six months**. Importantly, the same consensus emphasizes that women vary greatly in the type and intensity of stimulation needed to reach orgasm.

That last point is extremely important.

A woman should not be labelled sexually dysfunctional simply because her orgasm does not occur in the way she has seen portrayed in films, read about online or expected from cultural myths.

The proper question is not merely:

“Do you reach orgasm during intercourse?”

I want to understand:

Can you experience orgasm under any circumstances? What type of stimulation works? Has this always been your pattern or has something changed? Is the problem causing you personal distress?

Only after answering those questions can we begin to understand whether treatment is actually needed.

What Is an Orgasm?

An orgasm is a complex sexual response involving the **brain, sensory nerves, spinal pathways, genital structures, pelvic-floor muscles, blood circulation and psychological experience**.

It is much more than a simple muscular contraction.

During adequate sexual arousal and stimulation, sensory information from the genital region travels through the nervous system and is processed by the brain. When the appropriate threshold is reached, many women experience an intense peak of pleasurable sensation accompanied by involuntary rhythmic pelvic-floor contractions, changes in breathing and heart rate and a feeling of sexual release.

The latest basic-science recommendations from the International Consultation on Sexual Medicine describe orgasm as a complex multimodal reflex involving genital sensory nerves, spinal pathways, brain mechanisms and pelvic muscular activity.

Current anatomical research also emphasizes that the **clitoris is a central structure in female sexual pleasure and orgasm**, while surrounding vulvar and vaginal tissues, nerves, vascular structures and pelvic-floor muscles also contribute to the sexual response.

Therefore, orgasm cannot be understood simply by looking at the vagina, uterus or hormones alone.

Anorgasmia Is Only One Type of Orgasmic Difficulty

The latest 2026 international consensus describes several ways in which orgasmic function can become problematic.

Anorgasmia means orgasm is absent.

Delayed orgasm means orgasm can occur, but it takes substantially longer than the woman desires.

Infrequent orgasm means orgasm occurs much less often than desired.

Muted orgasm means orgasm occurs but feels significantly less intense.

Anhedonic orgasm means the physical orgasmic response may occur but the expected pleasure is absent or greatly reduced.

The current definition therefore focuses on **frequency, intensity, timing and pleasure**, rather than asking only whether an orgasm happened.

This broader understanding makes sexual-health assessment much more accurate.

Lifelong Anorgasmia: "I Have Never Experienced an Orgasm"

When a woman has never experienced orgasm under any circumstances, the problem is often described as **lifelong or primary anorgasmia**.

The woman may have:

normal sexual desire,

normal attraction,

normal lubrication,

normal genital anatomy,

and pleasurable sexual activity,

yet never have experienced the recognizable peak of orgasm.

Some women with lifelong anorgasmia have never had an opportunity to learn what type of stimulation their body needs.

Others grew up with strong sexual guilt, fear or misinformation.

Some experience performance anxiety.

Some are receiving insufficient or inappropriate stimulation.

A smaller proportion may have neurological, anatomical, medication-related or other medical contributors.

The latest ICSM definition specifically classifies Female Orgasmic Disorder as **lifelong** when it has been present throughout the woman's sexual life.

Lifelong anorgasmia should not automatically be interpreted as permanent.

Many women can improve substantially after appropriate sexual education, self-awareness, behavioral treatment, communication and treatment of any underlying physical or psychological problem.

Acquired Anorgasmia: "I Used to Have Orgasms but Now I Cannot"

This situation often requires a different clinical approach.

When orgasm was previously normal and then becomes difficult or disappears, I look carefully for **what changed around the time the problem began**.

Possible factors include:

a new medication,

depression,

anxiety,

relationship change,

childbirth,

menopause,

new pelvic pain,

vaginal dryness,

pelvic surgery,

cancer treatment,

neurological illness,

diabetes,

chronic disease,

or significant changes in sexual stimulation.

The 2026 international consensus describes this pattern as **acquired Female Orgasmic Disorder**—the difficulty develops after a period of previously satisfactory orgasmic function.

An acquired change is therefore often an important clinical clue.

Rather than immediately prescribing a sexual tonic, we should ask:

What happened before the orgasmic difficulty appeared?

Generalized and Situational Anorgasmia

Another useful distinction is whether orgasmic difficulty occurs **everywhere or only in certain circumstances**.

In **generalized anorgasmia**, the woman cannot reach orgasm regardless of the situation.

In **situational orgasmic difficulty**, orgasm is possible in some circumstances but not others.

For example, a woman may experience orgasm during self-stimulation but not with a partner.

Another may reach orgasm with one type of stimulation but not during vaginal intercourse.

Another may have previously reached orgasm with a former partner but not in her current relationship.

The latest ICSM consensus recognizes this distinction between **generalized and situational** Female Orgasmic Disorder.

This distinction is clinically valuable because a woman who can orgasm in one situation clearly has the neurological capacity to experience orgasm.

The question becomes:

What is different about the circumstances in which orgasm does not occur?

That directs us toward stimulation technique, communication, anxiety, relationship context or other situational factors.

Not Reaching Orgasm From Penetration Alone Is Not Automatically a Disorder

This is one of the most important myths I address.

Some women believe:

“If I need clitoral stimulation, something must be wrong with me.”

That belief can create unnecessary anxiety.

Female sexual anatomy does not support the idea that every woman should automatically climax from vaginal penetration alone.

The clitoris has a major role in female orgasm, and current anatomy literature emphasizes its importance in female sexual response.

The 2026 international consensus also states explicitly that women show **wide variation in the type and intensity of stimulation required to reach orgasm**.

Therefore, needing direct or indirect clitoral stimulation should not be treated as a defect.

If a woman experiences satisfying orgasms through one form of stimulation but not penetration alone and is not distressed by this, she does not necessarily require medical treatment.

Sexual medicine should not turn normal variation into disease.

Is Female Orgasmic Disorder Common?

Orgasm difficulties are not rare, although estimates vary greatly depending on how researchers define the problem.

A major contemporary clinical review published in 2026 reported that Female Orgasmic Disorder affects approximately **10%–28% of women**, depending on the population and diagnostic definition used.

However, simple difficulty reaching orgasm is much more common than a clinically distressing disorder.

The newest international consensus emphasizes the importance of this distinction. In large population studies, **distressing orgasm difficulties** were reported in approximately 5.8% of women in one German study, 12.2% of sexually active women in a Danish study and 6.8% in a Belgian study. Rates become much higher when distress is not required as part of the definition.

This is why I do not diagnose a woman based merely on whether she always reaches orgasm.

Personal distress matters.

Is Orgasm Necessary for a Healthy Sexual Relationship?

No.

Some women enjoy intimacy, arousal, affection and sexual pleasure without always reaching orgasm and do not consider this a problem.

ACOG specifically notes that difficulty reaching orgasm is common and that some people feel satisfied with love and closeness during sexual activity even without orgasm. An orgasmic disorder becomes clinically relevant when the difficulty is personally problematic.

Sexual health should therefore never be reduced to:

“Did an orgasm occur—yes or no?”

Pleasure, connection, consent, comfort and satisfaction are also important.

However, when a woman wants to experience orgasm and consistently cannot, that concern deserves proper attention.

What Causes Anorgasmia?

There is rarely one universal cause.

Female orgasm is produced through a complex interaction of **biological, psychological and relationship factors**.

A recent 2026 review emphasizes the importance of a comprehensive biopsychosocial evaluation, including sexual history, clitoral anatomy, pelvic-floor function and selective medical testing.

I therefore prefer to divide possible causes into several overlapping areas.

Inadequate or Inappropriate Sexual Stimulation

Sometimes the simplest explanation is the most important.

A woman may have never received the type, intensity or duration of stimulation her nervous system requires.

Some couples assume that penetration should automatically produce orgasm.

If that does not happen, the woman is labelled “weak” or “cold.”

But the problem may simply be that stimulation is not adequately involving the most sensitive sexual structures.

ACOG recommends spending more time on sexual stimulation, trying different forms of stimulation and, when appropriate, considering sexual devices such as vibrators for women struggling to achieve orgasm.

This is sexual-health education—not a statement that every woman should use the same technique.

Women differ greatly.

Lack of Knowledge About Female Sexual Anatomy

Many women have received little or no accurate sexual education.

Some know far more about the uterus and pregnancy than about the clitoris.

Some have never explored what kind of stimulation is pleasurable.

Some feel embarrassed even looking at their own anatomy.

Modern reviews stress that accurate understanding of clitoral and vulvovaginal anatomy is essential for clinicians treating female sexual dysfunction.

Education itself can therefore be an important part of treatment.

A woman cannot easily communicate what she enjoys if she has never been given an opportunity to understand her own sexual response.

Performance Anxiety: "Why Am I Not Reaching Orgasm Yet?"

The harder someone tries to force an involuntary response, the more difficult it may become.

A woman begins thinking:

"Is it happening yet?"

Then:

"Why is it taking so long?"

Then:

"My partner must be getting frustrated."

Her attention moves away from pleasurable sensation and toward monitoring performance.

Sex becomes an examination.

This pattern may strongly interfere with orgasm.

The objective of sexual therapy is therefore often to move attention away from **performance and outcome** and back toward sensation, pleasure, connection and relaxation.

Stress, Anxiety and Depression

Mental health has a powerful relationship with sexual function.

Depression may reduce desire, pleasure and emotional engagement.

Anxiety can make relaxation difficult.

Chronic stress may leave the person mentally preoccupied even when sexual stimulation is physically adequate.

Mayo Clinic identifies depression, anxiety, psychological stress and relationship stress among important contributors to female sexual dysfunction.

The correct treatment may therefore include mental-health care rather than additional sexual medication.

Guilt, Shame and Cultural Conditioning

Some women have been taught from childhood that female sexual pleasure is embarrassing or inappropriate.

Such beliefs can remain active even in a loving marriage.

A woman may consciously want intimacy but unconsciously become tense or distracted as sexual excitement increases.

She may worry:

“Should I be feeling this?”

or:

“What will my partner think of me?”

These beliefs can interfere with sexual letting-go.

Cultural and personal values should always be respected, but harmful shame can be addressed through sensitive education or counseling without attacking the woman's beliefs or dignity.

Relationship Difficulties

Orgasmic function can be influenced by:

poor communication,

lack of trust,

resentment,

relationship conflict,

feeling emotionally disconnected,

sexual pressure,

or difficulty telling a partner what type of stimulation feels pleasurable.

A woman may experience orgasm alone but not with a partner because she feels more relaxed and can control stimulation more precisely when alone.

That does not necessarily mean she does not love or desire her partner.

It may mean the partnered sexual environment needs better communication.

Medication-Induced Anorgasmia

This is one of the most important acquired causes.

Certain medicines can interfere with sexual desire, arousal and orgasm.

Selective serotonin reuptake inhibitors (SSRIs) and some other antidepressants are particularly well known for causing delayed orgasm or inability to reach orgasm in some women.

ACOG lists antidepressants and several other medication categories among potential causes of sexual problems, while Mayo Clinic notes that medicines used for depression, hypertension, allergies and cancer may make orgasm more difficult.

If orgasmic difficulty began after starting or increasing a medication, tell the prescribing clinician.

Do not stop antidepressants or other essential medicines suddenly.

Sometimes the underlying medication can be adjusted, switched or supplemented when clinically appropriate.

A 2025 systematic review of treatments for antidepressant-induced sexual dysfunction in women found that bupropion improved orgasm scores in some trials, but the evidence quality was rated low. Such management therefore belongs under medical supervision rather than self-treatment.

Hormonal Changes and Menopause

Female sexual response can change during perimenopause and menopause.

Lower estrogen may contribute to:

vaginal dryness,

reduced genital comfort,

pain during intercourse,

and tissue changes.

Pain and inadequate arousal can then make orgasm much harder.

Menopause may also coincide with changes in sleep, mood, chronic illness, medications and relationship circumstances.

Hormone therapy is **not a universal treatment for anorgasmia**.

However, when vaginal dryness or menopausal tissue changes are interfering with sexual activity, appropriate local or systemic treatment may improve comfort and indirectly improve sexual response.

Mayo Clinic notes that local vaginal estrogen can improve genital blood flow and lubrication in appropriate patients, but hormonal treatments carry individual indications and risks and require medical assessment.

Pregnancy, Childbirth and the Postpartum Period

Sexual function may change substantially following childbirth.

A woman may be dealing with:

sleep deprivation,

breastfeeding-related hormonal changes,

pelvic-floor injury,

vaginal dryness,

pain,

scarring,

body-image changes,

and the demands of caring for a newborn.

These circumstances can alter arousal and orgasm even when emotional attraction remains strong.

If the change is temporary and not distressing, reassurance may be sufficient.

Persistent difficulty—especially when accompanied by pelvic-floor symptoms or pain—deserves assessment.

Pelvic-Floor Dysfunction

The pelvic-floor muscles participate in orgasmic contractions.

If the muscles are poorly coordinated, excessively tight, painful or weak, sexual response may be affected.

A systematic review and meta-analysis found that pelvic-floor muscle training improved orgasm and several other Female Sexual Function Index domains in some studies. However, the certainty of evidence was rated very low because treatment methods and patient groups varied considerably.

The practical lesson is important:

Pelvic-floor therapy may be helpful for selected women.

But women should not automatically perform aggressive Kegel exercises.

A hypertonic or painful pelvic floor may require relaxation and specialized physiotherapy rather than more strengthening.

Sexual Pain and Vulvodynia

It is difficult to reach orgasm while anticipating pain.

Vulvodynia, dyspareunia, vaginismus, endometriosis, pelvic-floor dysfunction, vaginal dryness and other pain conditions can make sexual activity uncomfortable.

When sex repeatedly hurts, the nervous system begins focusing on protection rather than pleasure.

ACOG emphasizes that sexual pain can result from gynecological disease or impaired sexual response and recommends evaluation when pain is frequent or severe.

In these cases:

Treat the pain first rather than simply prescribing an orgasm-enhancing medicine.

Diabetes

Diabetes can affect sexual function through several mechanisms.

Long-term diabetes may affect:

nerve function,

blood circulation,

genital sensation,

energy levels,

mood,

and overall health.

Mayo Clinic includes diabetes among medical conditions capable of contributing to female sexual dysfunction.

A woman with acquired loss of genital sensation and longstanding diabetes therefore needs a broader medical assessment rather than assuming the issue is purely psychological.

Neurological Conditions

Orgasm depends on intact communication among the genital nerves, spinal cord and brain.

Conditions affecting these systems may interfere with orgasm.

Examples include:

multiple sclerosis,

spinal-cord injury,

certain neuropathies,

brain disease,

and pelvic nerve injuries.

Mayo Clinic identifies neurological disorders including multiple sclerosis and spinal-cord conditions as risk factors for female sexual dysfunction.

The extent of dysfunction depends on which pathways are affected.

Pelvic Surgery and Radiation Treatment

Some women develop orgasmic changes after pelvic surgery or radiation.

ACOG identifies surgery or pelvic radiation as possible causes of acquired orgasmic difficulty, although they are less common than many psychological, medication-related or relationship factors.

A woman who develops sudden sexual numbness or complete loss of orgasm after pelvic surgery deserves appropriate gynecological or neurological assessment.

Cancer and Cancer Treatment

Cancer can influence sexual health through several pathways:

surgery,

radiotherapy,

chemotherapy,

hormonal therapies,

fatigue,

menopausal changes,

body-image concerns,

depression,

and relationship stress.

The correct approach should therefore consider both cancer survivorship and sexual rehabilitation.

Sexual concerns after cancer treatment are legitimate quality-of-life concerns and should not be dismissed.

Alcohol and Recreational Substances

Small amounts of alcohol may reduce inhibition for some people, but heavier alcohol use can impair arousal, sensation and orgasmic response.

Other psychoactive substances can also interfere with sexual functioning.

A careful sexual-health assessment therefore includes substance use without judgment.

Orgasmic Difficulty and Infertility

Because my practice focuses on both **sexual disorders and infertility**, I frequently see how these two areas influence one another.

Anorgasmia itself is **not usually a direct biological cause of infertility**.

A woman does not need an orgasm for fertilization to occur.

However, infertility treatment can create substantial sexual pressure.

Intercourse may become scheduled exclusively around ovulation.

The couple stops thinking about intimacy and starts thinking:

“We have to perform tonight because this is the fertile day.”

Performance anxiety develops.

The woman may become focused on conception rather than pleasurable sensations.

The male partner may develop erection or ejaculation anxiety.

Sex gradually feels like treatment rather than intimacy.

This can reduce orgasmic responsiveness even in women who previously experienced orgasm normally.

At Saira Health Care, I consider preservation of the couple's sexual relationship an important part of fertility care.

How Do I Evaluate a Woman With Anorgasmia?

There is no blood test that simply says:

“This woman has anorgasmia.”

Diagnosis depends primarily on understanding the woman's experience.

Current 2026 clinical literature recommends a **comprehensive biopsychosocial assessment**, including detailed sexual history, appropriate physical examination, attention to clitoral anatomy and pelvic-floor function, and selective—not indiscriminate—laboratory testing.

When a woman comes to me with orgasm difficulty, I want to understand several things.

Was orgasm ever possible?

Did the problem exist from the beginning?

Can orgasm occur during self-stimulation?

Does it occur with particular forms of stimulation but not others?

Does she feel sexual desire?

Does she become mentally aroused?

Is genital sensation normal?

Is there vaginal dryness?

Is there pain?

Has medication changed?

Did the problem begin after childbirth, menopause, surgery or illness?

Is there depression, anxiety or relationship conflict?

Does she feel comfortable communicating her preferences to her partner?

Has she been given realistic information about female sexual anatomy?

These answers frequently explain much more than laboratory testing.

Physical Examination

Not every woman with lifelong situational orgasm difficulty requires extensive physical investigation.

But examination may be appropriate when symptoms suggest a medical cause.

Depending on the patient's history, assessment may include:

general medical evaluation,

gynecological examination,

assessment of vulvar and clitoral anatomy,

genital sensation,

pelvic-floor muscle function,

vaginal tissue health,

and neurological findings when relevant.

The most recent 2026 clinical review specifically highlights **clitoral anatomy and pelvic-floor function** as important aspects of evaluation.

The examination should always be respectful, explained beforehand and performed with informed consent.

Laboratory Testing

Laboratory tests should be **guided by symptoms**, not ordered automatically.

Depending on the individual case, a clinician might consider:

thyroid testing,

blood glucose or HbA1c,

prolactin,

or other endocrine investigations.

However, no single female hormone level diagnoses anorgasmia.

Sexual response is much too complex to be explained by one number.

Treatment Depends on Why Orgasm Is Difficult

The most important principle of treatment is:

There is no single universal medicine for female anorgasmia.

Current research supports a biopsychosocial approach that combines sexual education, psychological treatment, behavioral interventions, relationship work, treatment of medical causes and selected physical interventions.

Treatment for a woman who has never learned which stimulation she needs should be very different from treatment for a woman whose orgasms disappeared after starting an SSRI.

Sexual Education Is a Genuine Treatment

Some patients expect treatment to begin with a tablet.

Sometimes it should begin with accurate information.

A woman may need reassurance that:

orgasm varies between individuals,

clitoral stimulation is normal,

penetration alone is not the only valid sexual activity,

different women require different intensity and duration of stimulation,

and sexual pleasure is not an examination she must pass.

ACOG recommends spending more time on stimulation and experimenting with different forms of sexual activity for women who have difficulty reaching orgasm.

Removing myths can itself reduce performance anxiety.

Directed Self-Exploration and Masturbation Training

One of the best-established behavioral approaches for lifelong anorgasmia is **directed masturbation training**, more appropriately described in patient education as structured self-exploration.

The objective is not simply “masturbation as treatment.”

It is helping the woman learn:

what type of touch feels pleasurable,

what pressure and rhythm are comfortable,

how arousal develops,

and how to recognize the progression toward orgasm.

A review of psychological and behavioral treatments concluded that the most consistent evidence for Female Orgasmic Disorder has historically supported **directed masturbation, sensate focus and psychotherapy**.

This can later help the woman communicate more effectively with a partner.

Vibratory Stimulation

A vibrator can provide consistent, concentrated stimulation and may help some women who have difficulty reaching orgasm.

ACOG includes sexual devices among self-help strategies for orgasm difficulties.

Mayo Clinic similarly notes that vibratory devices may help orgasm by increasing clitoral stimulation and genital blood flow.

This should not be presented as mandatory.

It is simply one therapeutic option.

A sexual device does not mean a partner has failed.

It is a tool—like many other tools used in healthcare—to help the nervous system receive the stimulation required for a particular response.

Sensate Focus

Sensate focus is a structured sex-therapy technique designed to reduce performance pressure.

Rather than making orgasm or penetration the immediate goal, attention is shifted toward sensation, touch, comfort and communication.

This can help break the cycle:

“I must orgasm → I become anxious → I monitor myself → arousal decreases → orgasm becomes even harder.”

Sensate-focus approaches remain among behavioral strategies with supportive evidence in female orgasmic difficulties.

Cognitive Behavioral Therapy

Cognitive behavioral therapy can be particularly useful when orgasm difficulty is maintained by:

performance anxiety,

negative beliefs,

body-image concerns,

sexual guilt,

fear,

or distracting thoughts.

A large systematic review and meta-analysis published in 2026 found that **mindfulness-based CBT significantly improved the orgasm domain of female sexual-function measures**, along with desire and arousal, in women with sexual dysfunction without pain conditions.

Psychological therapy should not be interpreted as saying:

“The problem is only in your head.”

The brain is a major sexual organ.

Attention, emotion and expectation influence physical sexual response.

Mindfulness

Mindfulness-based treatment teaches the woman to notice bodily sensation without continuously judging whether the “correct” response is happening.

Instead of asking:

“Am I close yet?”

the patient learns to notice:

“What am I feeling right now?”

This can reduce distracting self-monitoring and anxiety.

The 2026 systematic review supports mindfulness-based CBT as one of the better-supported contemporary psychological approaches across desire, arousal and orgasmic difficulties.

Partner Communication

A woman cannot expect her partner to automatically know what stimulation she needs.

Likewise, a partner should not feel criticized simply because another technique is needed.

Sexual communication can involve explaining:

which touch feels comfortable,

which type of stimulation works,

whether more time is required,

what produces distraction,

and what produces pressure.

The objective should be cooperation rather than performance evaluation.

A healthy statement might be:

“This is what helps me respond.”

rather than:

“You are doing everything wrong.”

Couple Therapy

When relationship conflict, resentment, trust difficulties or sexual communication problems are major contributors, couple therapy can be more useful than treating the woman in isolation.

Female sexual function occurs within a relationship context for many patients.

Sometimes the clinically relevant “patient” is therefore the **relationship**, not one partner's body.

Pelvic-Floor Physiotherapy

Pelvic-floor therapy may help selected women, particularly when there is:

pelvic-floor weakness,

poor muscle coordination,

pain,

or abnormal pelvic tension.

A 2024 systematic review and meta-analysis found improvements in orgasm, arousal, satisfaction and overall sexual-function scores following pelvic-floor muscle training,

although the authors emphasized that the certainty of evidence was very low because studies were heterogeneous.

This means pelvic-floor therapy is a useful option—but not a guaranteed treatment for every woman.

The pelvic floor should be assessed before exercises are prescribed.

Treat Vaginal Dryness and Sexual Pain

If intercourse is dry or painful, the woman may not receive the sustained pleasurable stimulation required for orgasm.

Depending on the cause, treatment may include:

lubrication,

vaginal moisturizers,

menopause-related treatment,

pelvic-floor therapy,

or management of vulvodynia or another gynecological condition.

ACOG recommends adequate lubrication and more time for arousal when pain or dryness is interfering with sexual activity.

Pain should never simply be ignored in pursuit of orgasm.

Medication Review

When acquired anorgasmia begins after starting a medication, the medication should be reviewed.

The clinician may sometimes:

adjust dosage,

change timing,

switch to a different treatment,

or add an intervention intended to reduce sexual side effects.

This must be individualized.

A woman should never stop antidepressants or other important medication abruptly because of sexual side effects.

Are There Medicines Specifically Approved for Female Anorgasmia?

At present, **there is no U.S. FDA-approved medication specifically for Female Orgasmic Disorder**.

The most recent 2026 clinical review emphasizes this point.

A number of medications have been investigated, including:

sildenafil,

bupropion,

hormonal approaches,

and other agents.

However, evidence is inconsistent or limited, and none should be described as a universal orgasm medicine.

This is important because advertisements sometimes suggest that one pill can solve every female sexual problem.

It cannot.

What About Sildenafil?

Sildenafil is established for erectile dysfunction in men, but female sexual response is not simply the male response in a different body.

Some studies have investigated sildenafil for particular female sexual problems, including medication-associated dysfunction, but evidence for routine treatment of Female Orgasmic Disorder remains insufficient.

It should therefore not be used casually or without appropriate medical advice.

What About Bupropion?

Bupropion is an antidepressant with a different pharmacological profile from SSRIs.

It has been studied particularly when sexual dysfunction is associated with antidepressant treatment.

A 2025 meta-analysis found improvements in several sexual-function domains, including orgasm, with bupropion SR, but rated the quality of the evidence as low.

Therefore, this is a clinician-directed treatment option in selected circumstances—not a general female sexual-enhancement medicine.

Hormonal Therapy

Hormones should be used to treat an appropriate hormonal or menopausal indication.

They should not be prescribed simply because a woman cannot orgasm.

If menopause-related vaginal dryness, pain or tissue changes are interfering with arousal, local estrogen or other appropriate menopausal treatment may improve comfort and facilitate sexual response.

Treatment should be selected after reviewing the woman's medical history and contraindications.

PRP, Stem Cells and "Regenerative Sexual Treatments"

Patients increasingly encounter advertisements for platelet-rich plasma injections, stem-cell treatment and other so-called regenerative procedures for female sexual enhancement.

A 2025 review notes that these approaches are being investigated, but contemporary evidence is not yet sufficient to establish them as standard treatment for Female Orgasmic Disorder.

I advise patients to be particularly cautious whenever an expensive procedure is promoted as:

"guaranteed orgasm restoration"

or

"permanent cure."

Such promises exceed the current evidence.

Treatment of Lifelong Anorgasmia

When a woman has never experienced orgasm and no major medical abnormality is present, treatment commonly focuses on:

accurate anatomy education,

reducing shame and performance anxiety,

structured self-exploration,

appropriate clitoral stimulation,

possible vibrator use,

sensate-focus exercises,

psychological treatment when needed,

and gradually incorporating successful stimulation into partnered intimacy.

Behavioral and psychological treatment has a meaningful evidence base in lifelong Female Orgasmic Disorder.

For many women, this is more appropriate than medication.

Treatment of Acquired Anorgasmia

When orgasm was previously normal, treatment should begin with the cause.

If symptoms began after an SSRI, review the medication.

If they appeared after menopause, evaluate dryness, pain and other menopausal symptoms.

If they followed pelvic surgery, assess sensation, nerve function and pelvic-floor status.

If depression developed, treat the depression.

If pain began, treat the pain.

If relationship circumstances changed, address the relationship context.

Acquired anorgasmia often improves most effectively when the factor that disrupted previously normal sexual function is identified.

Orgasmic Difficulty After Cancer Treatment

Women who have undergone pelvic surgery, chemotherapy, radiotherapy or hormone treatment may experience changes in sexual sensation and orgasm.

In these patients, treatment should be integrated into survivorship care.

Depending on the problem, rehabilitation may involve:

treatment of vaginal dryness,

pelvic-floor therapy,

management of neuropathic symptoms,

sexual counseling,

or appropriate gynecological and oncology collaboration.

Cancer survival should include attention to quality of life—including sexual health.

The Role of Unani Medicine in Female Anorgasmia

As a physician trained in the Unani system of medicine, I believe Unani medicine offers an important **whole-person perspective** on sexual and reproductive health.

At the same time, responsible contemporary Unani practice must distinguish between **traditional use** and **modern clinical evidence**.

There is currently **insufficient high-quality evidence showing that a particular Unani formulation can reliably cure Female Orgasmic Disorder or lifelong anorgasmia**.

Therefore, I do not believe a complex orgasmic disorder should simply be labelled “sexual weakness” and treated with an aphrodisiac.

The strongest contribution of Unani medicine in this area is through its **individualized assessment of general health, lifestyle, psychological well-being, sleep, physical activity, nutrition and associated illnesses**, combined where appropriate with safe supportive treatment.

The Unani Concept of Sexual Health

Classical Unani medicine discusses conditions broadly described under **Zu'f-i-Bah**, or sexual debility.

Official CCRUM treatment guidelines recognize that diminished sexual capacity may involve not only physical factors but also **psychological factors**, and the traditional management principles include attention to psychological contributors.

However, I want to make an important distinction.

Classical *Zu'f-i-Bah* should not automatically be equated with modern Female Orgasmic Disorder.

Modern sexual medicine gives us more precise categories.

A woman may have perfectly normal desire and arousal but difficulty with orgasm.

Another may have normal orgasm but reduced desire.

Another may have painful intercourse.

These require different treatment.

Asbab Sitta Daruriyya and Female Sexual Well-Being

Unani medicine traditionally emphasizes the essential determinants of health known as **Asbab Sitta Daruriyya**.

These include regulation of:

air and environment,

food and drink,

physical movement and rest,

mental activity and peace,

sleep and wakefulness,

and processes of retention and evacuation.

This holistic framework is particularly useful when assessing sexual-health complaints because orgasm does not exist separately from general health.

A woman who is chronically exhausted, severely stressed, physically unwell or sleeping poorly may struggle with sexual responsiveness even when her genital anatomy is normal.

Ilaj-bil-Ghiza — Dietotherapy

I am sometimes asked:

“Which food will make orgasm happen?”

There is no scientifically established food that directly cures anorgasmia.

The purpose of Unani dietotherapy in this context should be more sensible.

Nutrition may support:

general energy,

healthy weight,

metabolic health,

diabetes management,

cardiovascular health,

and nutritional adequacy.

These areas can indirectly support sexual function.

The patient should not be subjected to extreme dietary restrictions or unproven “orgasm diets.”

Ilaj-bil-Tadbir — Regimental and Lifestyle Care

CCRUM identifies **Ilaj-bil-Tadbir** as one of the major therapeutic approaches of Unani medicine alongside dietotherapy and pharmacotherapy.

For sexual-health patients, supportive lifestyle management may include:

regular physical activity,

adequate rest,

sleep correction,

stress reduction,

healthy routine,

and improving general physical fitness.

These measures will not necessarily produce an orgasm by themselves.

But they can improve the physical and psychological environment in which healthy sexual response occurs.

Ilaj Nafsani — Psychological Care

The importance of psychological care is especially relevant in anorgasmia.

CCRUM's training material for women's healthcare explicitly recognizes **Ilaj Nafsani, or psychological therapy**, as part of Unani therapeutic modalities.

This fits particularly well with modern treatment of orgasmic difficulty.

Performance anxiety, shame, relationship stress and negative sexual beliefs often require:

education,

counseling,

CBT,

sex therapy,

or couple therapy.

Integrating psychological understanding with physical health is one of the areas where traditional holistic care and contemporary sexual medicine can complement one another.

Ilaj-bil-Dawa — Unani Medicines

Unani pharmacotherapy has traditionally included preparations used for sexual debility.

However, a traditional classification such as **Muqawwi-i-Bah** does not prove effectiveness for modern Female Orgasmic Disorder.

I therefore believe medication should be individualized and used only after answering several questions:

Does the woman actually have an orgasmic disorder?

Is the problem lifelong or acquired?

Is she taking medications that may be causing it?

Is there diabetes, neurological disease or menopause?

Is sexual pain present?

Could pregnancy occur?

What other medications or supplements is she using?

If these questions are ignored, prescribing a “sexual tonic” may distract from the real problem.

Avoid Unregulated Sexual-Enhancement Products

Women should be cautious about products sold online with claims such as:

“instant female orgasm,” “permanent sexual power,” or “guaranteed climax.”

Sexual-health products may contain poorly studied combinations or interact with prescription medicines.

Even herbal products can cause adverse effects.

The word **natural** does not automatically mean safe.

At Saira Health Care, my preference is to understand the patient's actual sexual-health condition before recommending any supportive Unani preparation.

Dr. Nizamuddin Qasmi's Specialized Approach to Anorgasmia

At **Saira Health Care**, I approach female anorgasmia as an individualized sexual-health condition rather than simply calling it sexual weakness.

My assessment begins by identifying the type of problem.

Is it lifelong?

Is it acquired?

Is it generalized?

Is it situational?

Can orgasm occur with self-stimulation but not with a partner?

Is sexual desire normal?

Is arousal normal?

Is there genital numbness?

Is there pain?

Is the pelvic floor functioning properly?

Did symptoms begin after a new medication?

Has childbirth or menopause changed sexual function?

Is infertility treatment creating pressure?

Are psychological or relationship factors present?

Once this pattern is clear, treatment can be targeted.

A Stepwise Integrative Treatment Philosophy

My first priority is **education and accurate diagnosis**.

The second is identifying reversible medical, medication-related, psychological or relationship factors.

The third is helping the woman understand her individual sexual response and stimulation needs.

Where appropriate, behavioral sexual therapy, psychological care, pelvic-floor rehabilitation, gynecological treatment or medication review can be incorporated.

Unani care may then support the patient's general health through individualized attention to nutrition, sleep, physical activity, psychological balance and associated conditions.

If neurological, gynecological, endocrine, psychiatric or other specialist assessment is required, referral should not be delayed.

That is what I mean by **integrative treatment**.

It does not mean replacing modern sexual medicine with herbs.

It means combining the most appropriate elements of care around the individual patient.

Contribution of Saira Health Care in Sexual Disorders & Infertility

At **Saira Health Care**, our clinical focus on sexual disorders and infertility allows us to address problems women frequently hesitate to discuss.

These include:

difficulty reaching orgasm,

low desire,

arousal difficulties,

painful intercourse,

vaginismus,

vulvodynia,

pelvic-floor dysfunction,

female fertility concerns,

and relationship-related sexual difficulties.

Sexual-health complaints are frequently interconnected.

A woman may first complain of anorgasmia, but further assessment reveals severe pain.

Another may have acquired anorgasmia caused by antidepressant treatment.

Another may be physically healthy but has never received appropriate stimulation.

Another may have developed performance anxiety during years of infertility treatment.

Therefore, our objective should not be to give every woman the same medicine.

It should be to **identify the reason the orgasmic response is not occurring and treat that reason appropriately**.

About Dr. Nizamuddin Qasmi

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

His qualifications and professional 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 is to combine the holistic background of Unani medicine with modern understanding of sexual and reproductive health.

For female orgasmic problems, that means respecting the woman's concerns without embarrassment, evaluating physical and psychological factors together and avoiding unrealistic promises.

Frequently Asked Questions About Female Anorgasmia

I have never had an orgasm. Does that mean I will never have one?

No.

Lifelong anorgasmia does not necessarily mean permanent inability.

Behavioral sexual education, directed self-exploration, appropriate stimulation, psychological treatment and partner communication can help many women. Reviews of behavioral treatment show particularly consistent support for directed masturbation, sensate focus and psychotherapy.

Is needing clitoral stimulation abnormal?

No.

The clitoris plays a central role in female orgasm, and women vary greatly in the stimulation required to climax.

I can orgasm alone but not with my husband. Is this anorgasmia?

This is more appropriately considered a **situational orgasmic difficulty** rather than generalized inability to orgasm.

The fact that orgasm occurs in one setting demonstrates that the orgasmic response is physiologically possible. Treatment can focus on differences in stimulation, communication, anxiety and sexual context.

Can stress stop orgasm?

Yes.

Stress, anxiety and depression can interfere with sexual response and concentration on pleasurable sensations.

Can antidepressants cause anorgasmia?

Yes.

SSRIs and some other antidepressants can delay or prevent orgasm in some women. Never discontinue them suddenly; discuss sexual side effects with the prescribing clinician.

Does menopause cause anorgasmia?

It may contribute, but not every menopausal woman develops orgasmic difficulty.

Dryness, pain, hormonal changes, medication, chronic illness and altered arousal can all play a role.

Can diabetes affect orgasm?

Yes.

Diabetes may affect nerves, blood vessels, sensation and overall sexual health.

Can pelvic-floor therapy help?

For selected women, yes.

Research suggests pelvic-floor training can improve orgasm and other sexual-function measures, although evidence quality is still limited and the exercise program should be individualized.

Is there an FDA-approved medicine specifically for female orgasmic disorder?

No.

As of 2026, no medication is FDA-approved specifically for Female Orgasmic Disorder. Several drugs have been investigated, but treatment remains individualized.

Can a vibrator be medically useful?

Yes.

Vibratory stimulation may help some women by providing strong and consistent clitoral stimulation, and ACOG includes sexual devices among options for orgasm difficulties.

Does a woman need to orgasm to become pregnant?

No.

Female orgasm is not required for fertilization. However, orgasmic difficulties and infertility treatment can both influence a couple's sexual satisfaction and should be addressed when they create distress.

Can Unani medicine help?

Unani medicine can contribute through a holistic approach emphasizing general health, diet, lifestyle, sleep, mental well-being and individualized supportive treatment. Traditional Unani literature also recognizes psychological contributors to sexual difficulties. However, there is currently insufficient high-quality evidence that any particular Unani medicine reliably cures Female Orgasmic Disorder, so modern sexual-health assessment should remain central.

When Should a Woman Seek Medical Advice?

Professional evaluation is particularly worthwhile when a woman has **never experienced orgasm and is distressed by this**, or when orgasm was previously normal and suddenly or gradually disappeared.

Earlier assessment is especially important if orgasmic loss occurs together with:

new genital numbness,

persistent pelvic pain,

painful intercourse,

vaginal bleeding,

significant vaginal dryness,

new neurological symptoms,

diabetes,

pelvic surgery,

radiation treatment,

major hormonal changes,

severe depression,

or symptoms beginning soon after a new medication.

ACOG encourages women to discuss sexual-health concerns openly with their healthcare professional and notes that sexual health is an important part of overall health.

There is no reason to feel embarrassed.

What the Latest Evidence Tells Us in 2026

Contemporary research has changed the way Female Orgasmic Disorder should be approached.

The newest international consensus recognizes that orgasmic dysfunction is not simply an all-or-nothing condition. Frequency, intensity, timing and pleasure may all be affected, and women naturally require different types and amounts of stimulation. Personal distress remains central to determining whether a normal variation should be classified as a disorder.

The latest 2026 clinical review emphasizes a **biopsychosocial diagnostic approach**, with attention to clitoral anatomy, pelvic-floor function, psychological factors, partner expectations and medical causes. It also confirms that no FDA-approved medication exists specifically for Female Orgasmic Disorder.

Meanwhile, the 2026 systematic review and meta-analysis of female desire, arousal and orgasm treatments found meaningful benefits from mindfulness-based cognitive behavioral therapy, while evidence for many other interventions remains too limited or heterogeneous to draw strong conclusions.

Taken together, these findings support a treatment philosophy I strongly agree with:

Do not search for one universal orgasm medicine. Understand the woman, understand the cause and then choose the treatment.

My Final Message to Women Experiencing Anorgasmia

If you have never experienced an orgasm, please do not immediately think:

“My body is defective.”

If you once experienced satisfying orgasms but can no longer reach them, please do not automatically conclude:

“My sexual life is over.”

There may be many explanations.

Perhaps the stimulation is not appropriate for your body.

Perhaps you were never given accurate sexual education.

Perhaps anxiety has turned sexual activity into a performance test.

Perhaps an antidepressant is interfering.

Perhaps menopause has made intimacy dry or painful.

Perhaps your pelvic-floor muscles are not functioning normally.

Perhaps diabetes or another medical condition is affecting sensation.

Perhaps years of infertility treatment have turned intimacy into a reproductive duty.

Or perhaps several factors are working together.

This is exactly why anorgasmia should be evaluated **without shame and without oversimplification**.

At Saira Health Care, my approach is not merely to ask:

“Which medicine increases sexual power?”

I want to know:

Is desire present?

Is arousal present?

What stimulation is being used?

Can orgasm occur in any situation?

Is the woman comfortable?

Is there pain?

Is medication contributing?

Is the pelvic floor healthy?

Has a medical condition changed sexual sensation?

What is happening emotionally and within the relationship?

Once those questions are answered, the treatment becomes much more logical.

Modern sexual medicine and the holistic strengths of Unani medicine can complement each other when used responsibly. General health, sleep, nutrition, exercise, emotional balance and relationship well-being matter—but they must be combined with accurate diagnosis, sexual education, appropriate psychological treatment and modern medical care whenever necessary.

Female orgasm should never be used as an examination of femininity, marital success or sexual worth.

Some women reach orgasm quickly.

Some require considerable time.

Some require very specific stimulation.

Some have never learned how their body responds.

And some have a genuine medical or psychological condition that deserves treatment.

The goal is not to force every woman into one definition of "normal."

The goal is to help each woman understand her own body, remove unnecessary fear and shame, identify treatable barriers, and—when orgasm is personally important to her—give her the best evidence-based and individualized opportunity to achieve a satisfying sexual response.

That, in my view, is respectful and responsible sexual healthcare.

Medical Disclaimer

This article is intended for general health education and does not replace individualized examination, diagnosis or treatment. Female orgasmic difficulty can result from medical illness, neurological disease, medication effects, pelvic-floor problems, menopause, sexual pain, psychological factors and relationship circumstances. Do not discontinue antidepressants, hormonal medicines or other prescribed treatment without medical supervision. Women with new genital numbness, neurological symptoms, significant pelvic pain, unexplained bleeding or major acquired changes in sexual function should seek appropriate professional evaluation. Unani medicines and supplements should also be individualized and should not be presented as guaranteed cures for anorgasmia.