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ORIGINAL

Clinical and psychosexual characterization of patients with female orgasmic disorder

Caracterización clínica y psicosexual de pacientes con trastorno orgásmico femenino

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ABSTRACT

Introduction: female orgasmic disorder (FOD) is a health problem that affects the physical and mental well-being of women, as well as their family, social and work balance. It has a high prevalence and incidence, and has organic and non-organic causes.
Objective: to characterize patients with FOD assessed in a specialized consultation over a 15-month period.
Method: a descriptive, observational, cross-sectional study was conducted. Theoretical, empirical and statistical-mathematical methods were used. In the sexual counseling and therapy consultation for sexual ailments at the National Center for Sexology (CENESEX) in Cuba, 39 patients diagnosed with FOD, ranging from 16 to 45 years, were characterized. Their clinical histories were reviewed and a questionnaire written by CENESEX specialists was used as a data collection procedure.
Results: in the evaluated patients with TOF, deficiencies related to sexual illiteracy were identified, particularly in relation to the organs of sexual response and the human sexual response cycle, attachment to mysticism and false beliefs, lack of knowledge of risk factors associated with TOF and inappropriate lifestyles.
Conclusions: the above shows that it is still necessary to provide tools that favor the care of these patients.

KEYWORDS

Sexual Dysfunctions; Female Sexual Dysfunction; Female Orgasmic Disorder.

RESUMEN

Introducción: el Trastorno Orgásmico Femenino (TOF) es un problema de salud que afecta el bienestar físico y mental de la mujer, así como su equilibrio familiar, social y laboral. De alta prevalencia e incidencia, tiene causas orgánicas y no orgánicas.
Objetivo: caracterizar a los pacientes con TOF valorados en consulta especializada en un período de 15 meses.
Método: se realizó un estudio observacional descriptivo, transversal. Se emplearon métodos teóricos, empíricos

y estadísticos matemáticos. En la consulta de orientación y terapia sexual para los malestares de la sexualidad del Centro Nacional de Sexología (CENESEX) de Cuba, se caracterizaron 39 pacientes diagnosticadas con TOF, entre 16 y 45 años. Se revisaron sus Historias Clínicas y como técnica de recolección de datos se utilizó un cuestionario redactado por especialistas del CENESEX.
Resultados: en las pacientes con TOF valoradas se identificaron insuficiencias relacionadas con el analfabetismo sexual, en particular en relación con los órganos de respuesta sexual y ciclo de respuesta sexual humana, apego al misticismo y creencias falsas, el desconocimiento de factores de riesgo asociados a la TOF y estilos de vida inapropiados.
Conclusiones: lo anterior evidencia que continúa siendo necesario proveer herramientas que favorezcan la atención a estas pacientes.

PALABRAS CLAVE

Disfunciones Sexuales, Disfunción Sexual Femenina, Trastorno Orgásmico Femenino.

INTRODUCTION

The World Health Organization defines human sexuality as: "a central aspect of human beings, present throughout their lives. It encompasses sex, gender identities and roles, eroticism, pleasure, intimacy, reproduction, and sexual orientation. It is experienced and expressed through thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and interpersonal relationships. Sexuality can include all these dimensions, but not all of them are always experienced or expressed. It is influenced by biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors. [1] Alterations in sexuality become a health problem that affects the physical and mental well-being of the individual and can alter family, work, and social balance. [2] For sexual health to be achieved, it is necessary that people's sexual rights be recognized and guaranteed. [1,3] The biological aspect of sexuality is related to sexual function through mental and perceptual changes that occur in response to sexual stimuli, but also physical changes, such as vascular, hormonal, and metabolic changes, among others, which ensure proper function and contribute to people's psychological well-being. [4]
Any difficulty during any phase of sexual activity that prevents an individual or couple from enjoying sexual activity is understood as sexual dysfunction. Sexual dysfunctions can have psychological or organic etiological factors. This distinction is a way of defining the approach to be taken. Organic causes include diabetes mellitus, high blood pressure, surgery, central nervous system diseases, anemia, hypothyroidism, vascular insufficiency, and side effects of drugs used to treat various conditions. Non-organic causes include stress, fatigue, lifestyle, anxiety, depression, grief, emotional loss, relationship conflicts, drugs, ignorance, repeated negative sexual interactions, restrictive and severe education, religious orthodoxy (guilt), personality disorders, and sexual orientation disorders. Sexual dysfunctions are more widely studied in men than in women, partly because of the cultural importance attached to penetration as the only socially valued sexual practice and partly because of the belief that the penis is the main and only virile anatomical instrument for sexual intercourse. However, women's sexuality is not determined by their biological differences from men but involves cultural, social, and economic factors that have their origins in gender inequality. As a result, they are more likely than men to develop anxiety, depression, and sexual disorders. Female sexual dysfunction (FSD) is classified as female sexual interest/arousal disorder, female orgasmic disorder (FOD), or genito-pelvic pain/penetration disorder. [7] FOD is established if at least one of the following symptoms is present in almost all or all instances of sexual activity: marked delay, marked infrequency, or absence of orgasm, or marked reduction in the intensity of orgasmic sensations.[5,6] The prevalence of FOD is high worldwide.[6] In a previous study conducted by these authors, up to 44 % of women who attended sex therapy had this disorder.[8] There are no selective drugs available for FSD, especially in postmenopausal women. [6] Given the pathophysiological complexity, multiple specialists must be involved in its management, always from a psychosexual perspective.[9] To define therapeutic guidelines for the treatment of FSD in our setting, it was necessary to characterize the patients with FSD evaluated in consultation, using various assessment instruments.

METHOD

A descriptive, cross-sectional observational study was conducted, accompanied by non-probabilistic intentional sampling, with patients diagnosed with TOF, aged between 16 and 45, who attended the sexual counseling and therapy clinic for sexual discomfort at the National Center for Sexology (CENESEX), Havana, Cuba, from October

2022 to January 2024. The following theoretical and empirical methods were used: theoretical approaches and historical-logical methods. Based on the interweaving of both, the references and background of the research were identified. Systemic method. This was used to understand the object of study.
Analytical-synthetic. This was used to define the theoretical and methodological foundations of the research. It was key in analyzing the results, allowing us to find the relationships between the whole and the parts. Empirical methods Documentary study. To obtain information about the research subject through the literature on sexual dysfunction, DFS, and TOF published in Cuba and worldwide.Survey. Used to assess aspects related to knowledge about comprehensive sexuality education, prevention, identification and control of risk factors, and sexual counseling to characterize the study population.Consultation with specialists. A group of specialists was selected to provide their opinions as a key source for validating the questionnaire developed for the study. Data on the characterization variables of the patients studied were obtained from the medical records prepared and established by the CENESEX Special Working Group on Sexology, which include general data, personal medical history, toxic habits, current history, sexual history, relationship status, physical examination, and laboratory tests, supplemented by a psychosexual interview. The variables characterizing FOT were age, level of education, occupation, skin color, marital status, inadequate sex education, knowledge of erogenous zones by women, and inappropriate sexual beliefs. The sociodemographic, clinical, and psychological variables were entered into a Microsoft Excel 2010 database (Microsoft Corp.; USA) and processed using descriptive statistics, with the results presented in tables.

RESULTS

Thirty-nine women diagnosed with TOF were included. The most representative age group was 30–39 years (46 %), followed by the 20–29 (25 %) and 40–45 (25 %) age groups. Only one patient under the age of 20 participated in the study (table 1).

Table 1. Distribution of patients by age group

Age group (years)	N	%
16 - 19	1	2,6
20 - 29	10	25,6
30 - 39	18	46,2
40 - 45	10	25,6
Total	39	100

The average age was 34 years, weight 66,7 kg, height 170 cm, and BMI 24,2 kg/m2 (table 2). Overweight patients predominated (51,3 %), followed by normal-weight patients (43,6 %); only one patient was obese, and one was underweight; none were severely obese. There was a predominance of white skin color (38,5 %), married marital status (43,6 %), university education level (64,1 %), and working women (48,7 %), and most had some toxic habit, as shown in table 2.

Table 2. Demographic and anthropometric characteristics of the patients included in the study

Variable	Media	DS⁺	Standard error	IC¥ (95 %)		IC (95 %)	
				LI£	LS×	LI	LS
Edad (años)	34,0	1,70	1,16	30,5	3,98	31,6	36,1
Peso (Kg)	66,7	8,48	1,36	50,1	11,1	64,1	69,4
Talla (cm)	1,70	0,08	0,01	1,54	0,11	1,68	1,73
IMC* (Kg/m²)	24,2	3,18	0,51	17,9	4,18	23,2	25,2

Notes: *BMI: Body Mass Index; +SD: Standard deviation; ¥CI: Confidence interval; £LI: Lower limit; ×LS: Upper limit

There was a predominance of women who did not have healthy lifestyles, as only 36 % exercised regularly or had a balanced diet. Fifty-nine percent of patients had some nervous disorder, mainly anxiety-depressive syndrome. Approximately half of the patients had diabetes, and two-thirds were hypertensive (table 3). Alcohol and cigarette consumption were predominant, particularly among those aged 20 to 39. The best lifestyle was observed in the age groups over 30. Nervous disorders and pathological history were prevalent in the older age group.

Table 3. General characteristics of the patients included in the study

Variable	Categories	N=39	%
Skin color	White	15	38,5
	Black	10	25,6
	Mestizo	14	35,9
Marital status	Married	17	43,6
	Divorced	8	20,5
	Single	7	17,9
	Accompanied	7	17,9
Level of education	Primary	-	-
	Secondary	-	-
	Pre-university	14	35,9
	University student	25	64,1
Occupation	Working woman	19	48,7
	Housewife	12	30,8
	Not required	8	20,5
Toxic habits	Yes	32	82,1
Lifestyle	Physical exercise	6	15,3
	Diet	8	20,5
Nervous disorders	Neurosis	3	7,7
	Depression	2	5,1
	Anxious depressive syndrome	18	46,2
Personal Medical History	Diabetes mellitus	21	53,8
	High blood pressure	26	66,7

On the other hand, 22 patients had a low to moderate level of knowledge about their erogenous zones. Meanwhile, inappropriate sexual beliefs accounted for almost two-thirds of all women. This is related to a predominance of poor sex education in 74,4 % of the women studied (table 4).

Table 4. Results of the psychosexual interview

Variable	Categories	N=39	%
Poor sex education	Yes	29	74,4
Knowledge of erogenous zones	High	17	43,6
	Low	8	20,5
	Medium	14	35,9
Inappropriate sexual beliefs	Yes	25	64,1

The age group with the least knowledge of their erogenous zones was 20-29 years old, with all patients having low to medium knowledge. This same group had 90 % of inappropriate sexual beliefs. However, the 30-39 age group had the most deficient sex education.

DISCUSSION

Sexual dysfunction is a health problem that frequently affects women, taking different clinical forms and being associated with multiple and varied factors, including toxic habits.[6] In this study, the presence of toxic habits among women, such as alcohol consumption, coffee consumption, and smoking, was significant, although they did not report drug use. Many people have considered alcohol to be a sexual stimulant and/or excitant. However, it has been found that in both men and women, it has adverse effects on the physiological signs of sexual arousal. Specifically, in women, it weakens the orgasmic response. Alcohol weakens masturbatory effectiveness, decreases the enjoyment and intensity of orgasm, and is a powerful depressant of the central nervous system, potentially causing irreversible endocrine, neurological, and vascular disorders that permanently reduce sexual response. In

the development of disorders related to the sexual sphere, poor sex education conditions, the existence of sexual prejudices, fear of performance, inadequate beliefs about how women should experience sexuality, and ignorance of the erogenous zones for greater pleasure, which can lead to the loss of the erotic bond with the partner and limit the enjoyment of sexuality as a couple and alone.[2] Our results show that poor sex education can lead to ignorance of erogenous zones and belief in sexual myths, despite efforts by health personnel to improve sex education at all stages of life.

The level of schooling is also a variable associated with sex education. The high percentages of women in university and the workforce are indicators of the achievements of our social system in terms of complete equality for women. Meanwhile, religious beliefs, among other factors, contribute to the existence of myths and taboos, such as the idea that women participate passively in sex to fulfill their reproductive duty and satisfy their partner.[2] Psychological factors are also very important for sexual health. Disorders such as anxiety and depression have a negative influence on the sexual response of women and their partners. Symptoms of depression isolate patients, lower self-esteem, and therefore reduce the sexuality that requires interaction with other people, which becomes less important and less interesting for depressed individuals.[2,6,7] The study found a prevalence of 46,2 % of anxiety-depressive syndrome. Diseases, in general, affect the sexual sphere of those who suffer from them. The study found that diabetes mellitus and high blood pressure were prevalent among the women studied. In particular, high blood pressure is described as a cause of FSD due to its pathophysiology and the medications used to treat it.[7,11] Decreased bioavailability of nitric oxide and smooth muscle vasodilation in the vagina and clitoris are involved in the pathophysiological mechanisms of TOF.[12] Diabetes causes decreased desire, anorgasmia, and difficulty with adequate vaginal lubrication during sexual intercourse.[13] Overweight and obesity influence the onset of sexual dysfunction in several ways, such as metabolically. They are common causes of hypothalamic-pituitary-gonadal dysfunction, which leads to body image dissatisfaction and reproductive disorders.[14] Metabolic syndrome is frequently associated with FSD.[15] The study found a prevalence of overweight women, which may be associated with the fact that most did not incorporate healthy lifestyles, such as diet and regular physical exercise.

The medical community must become aware of the complexity of FSD, especially TOF, and its association with multiple risk factors and health variables. Knowledge and characterization of the problem will enable comprehensive medical care to achieve a pleasurable sexuality that is an indicator of quality of life.

CONCLUSIONS

The results obtained in this research highlight the need to create tools that promote care for patients with TOF through primary health care and sexual health care groups.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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