Absent Female Orgasm (Female Orgasmic Disorder / Anorgasmia): Causes, Diagnosis, Treatment and the Role of Unani Medicine

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Introduction: "Doctor, I Enjoy Intimacy but I Cannot Reach Orgasm"

One of the most sensitive questions a woman may ask me is:

"Doctor, I feel sexual desire and sometimes enjoy intimacy, but I cannot reach orgasm. Is something wrong with me?"

Another patient may say:

"Earlier I could reach climax, but for the last few months I cannot."

Some women tell me:

"I can reach orgasm during self-stimulation but not during intercourse."

And another woman may have never experienced an orgasm at all.

All of these situations are different, and they should not automatically be treated in the same way.

The medical term commonly used for persistent difficulty reaching orgasm is **female orgasmic disorder**, while the word **anorgasmia** is often used when orgasm is absent.

Female orgasmic difficulties are common but frequently remain hidden because many women feel embarrassed to discuss sexual pleasure, especially in societies where female sexuality is rarely discussed openly.

The American College of Obstetricians and Gynecologists notes that sexual difficulties affect many women at some stage of life and that problems involving **desire, arousal, orgasm and sexual pain** frequently overlap.

A recent 2026 medical review estimated that female orgasmic disorder may affect approximately **10–28% of women**, although the exact figure varies according to population, definitions and how distress is measured.

My first message to every woman experiencing this problem is:

You should not feel ashamed, guilty or "incomplete."

Orgasm is influenced by the brain, nerves, blood flow, hormones, genital anatomy, pelvic-floor muscles, emotional comfort, quality of stimulation, medication, relationship dynamics and many other factors.

Therefore, absent orgasm is rarely understood properly by simply saying:

"You have sexual weakness."

At **Saira Health Care**, my approach is to understand the complete sexual, emotional, medical and reproductive picture before recommending treatment.

What Is a Female Orgasm?

An orgasm is an intense pleasurable response that may occur after sufficient sexual stimulation.

It involves the nervous system, brain, genital sensory pathways and pelvic-floor muscles.

Women commonly describe orgasm as a combination of:

- increasing sexual pleasure,
- a feeling of reaching a peak,
- involuntary rhythmic pelvic contractions in some women,
- release of sexual tension,
- increased heart rate and breathing,
- genital sensitivity,
- and a feeling of relaxation or satisfaction afterward.

However, orgasm does **not feel exactly the same in every woman**.

Some orgasms are intense.

Some are subtle.

Some women experience multiple orgasms.

Others experience one orgasm and then require time before further stimulation feels comfortable.

There is no single “correct” female orgasm.

Modern research emphasizes that the **clitoris is the principal anatomical organ involved in female orgasmic response**, although sexual sensation involves a much wider network of genital, pelvic, nervous and psychological pathways.

Understanding this anatomy is extremely important because many women incorrectly believe that they must be able to reach orgasm through vaginal penetration alone.

That is not true.

For many women, direct or indirect **clitoral stimulation** is especially important for reaching orgasm.

What Is Absent Female Orgasm?

Female orgasmic disorder is generally characterized by one or more of the following despite adequate sexual stimulation:

- orgasm is absent,
- orgasm occurs very infrequently,
- orgasm takes an unusually long time,
- or orgasm is markedly less intense than it was previously.

Modern diagnostic approaches also consider whether the problem is **persistent and causes significant personal distress**.

This last point is extremely important.

If a woman rarely experiences orgasm but is comfortable and satisfied with her sexual relationship, she does not necessarily have a disorder requiring medical treatment.

Sexual medicine should not turn normal human variation into disease.

We consider treatment particularly important when the woman herself experiences:

- frustration,
- distress,

- loss of sexual satisfaction,
- relationship difficulty,
- anxiety,
- reduced confidence,
- or significant deterioration from her previous sexual function.

Types of Female Orgasmic Difficulty

During consultation, I try to determine exactly what type of problem the woman has.

1. Lifelong or Primary Anorgasmia

In this situation, the woman reports:

"I have never experienced an orgasm."

She may nevertheless experience:

- sexual attraction,
- desire,
- genital arousal,
- lubrication,
- pleasure during intimacy,
- and emotional closeness.

But she has never reached what she recognizes as orgasm.

This condition often requires education, exploration of stimulation, psychological assessment and sometimes directed self-stimulation rather than medication alone.

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2. Acquired or Secondary Anorgasmia

Here, a woman who could previously reach orgasm begins having difficulty or becomes completely unable to do so.

This distinction is important because something has changed.

Possible causes include:

- a new medication,
- antidepressant treatment,

- relationship changes,
- menopause,
- childbirth,
- pelvic surgery,
- illness,
- chronic pain,
- psychological stress,
- depression,
- anxiety,
- or another medical problem.

The question therefore becomes:

“What changed around the time the orgasm problem started?”

That question can sometimes guide the entire diagnosis.

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3. Generalized Orgasmic Difficulty

A generalized problem means orgasm is difficult or absent in almost every situation, including:

- intercourse,
- partner stimulation,
- oral or manual stimulation,
- and self-stimulation.

This may require a different evaluation from a woman who can orgasm easily alone.

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4. Situational Orgasmic Difficulty

A woman may be able to reach orgasm in certain situations but not others.

For example:

“I can orgasm during self-stimulation but not with my husband.”

This does not necessarily indicate a hormonal or physical disease.

It may instead relate to:

- type of stimulation,
- communication,
- comfort,
- privacy,
- performance anxiety,
- insufficient arousal time,
- relationship dynamics,
- or differences between the stimulation used alone and during partnered sex.

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5. Delayed Orgasm

Some women can reach orgasm, but only after a very long period of stimulation.

The important question is whether this represents her normal pattern or whether it is causing distress.

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6. Reduced-Intensity Orgasm

Another woman may tell me:

“I am still having orgasm, but it feels much weaker than before.”

This can occur with:

- hormonal changes,
- medication,
- aging-related changes,
- pelvic-floor changes,
- nerve problems,
- psychological factors,
- reduced arousal,
- or changes in sexual stimulation.

Orgasm Is Different From Sexual Desire

This is an extremely important distinction.

A woman may have:

Normal desire but difficulty achieving orgasm

or

Low desire but normal orgasm once sufficiently stimulated

or

Normal desire and orgasm but pain during intercourse

or

Difficulty with both arousal and orgasm.

These are not the same condition.

At Saira Health Care, I try not to label all female sexual problems simply as “low sexual power.”

Modern sexual medicine recognizes separate but overlapping problems involving:

1. sexual desire,
2. sexual arousal,
3. orgasm,
4. genital or pelvic pain,
5. and medication- or substance-associated dysfunction.

Correct diagnosis is therefore the foundation of treatment.

Causes of Absent Female Orgasm

Female orgasm is a **biopsychosocial phenomenon**.

This means biological, psychological and social factors interact with each other.

A recent clinical review emphasizes that female orgasmic disorder requires comprehensive evaluation of medical, psychological, relational, anatomical and sexual factors rather than looking for a single universal cause.

Let us understand these causes one by one.

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1. Inadequate Sexual Stimulation

This is one of the most overlooked causes.

Many women who believe they are physically incapable of orgasm may simply never have received the kind of stimulation their body requires.

For some women, vaginal penetration alone does not provide sufficient stimulation.

Direct or indirect clitoral stimulation may be necessary.

Possible difficulties include:

- intercourse ending too quickly,
- insufficient foreplay,
- lack of clitoral stimulation,
- fear of telling the partner what feels pleasurable,
- repetitive stimulation that is uncomfortable rather than pleasurable,
- or concentrating so strongly on “trying to orgasm” that relaxation becomes impossible.

The ACOG recommends allowing more time for stimulation, exploring different methods and, when appropriate, using sexual devices as part of managing orgasmic difficulty.

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2. Lack of Sexual Knowledge

Some women reach adulthood without receiving accurate information about female sexual anatomy.

They may not know:

- where the clitoris is,
- how sexual arousal develops,
- that lubrication and orgasm are different,
- that penetration alone does not guarantee orgasm,
- or what type of stimulation they personally prefer.

I therefore consider **sexual education itself a form of treatment**.

A woman should understand her own body before concluding that her body is defective.

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3. Performance Anxiety

Trying too hard to reach orgasm can sometimes prevent it.

A woman may think:

“Why is it taking so long?”

“My husband must think something is wrong.”

“Everyone else can orgasm—why can't I?”

“I must reach climax before he finishes.”

At that moment, attention moves away from pleasure and toward performance.

The woman begins observing and judging herself instead of experiencing sensation.

This phenomenon is sometimes described clinically as **spectatoring**—watching and evaluating one's own performance rather than remaining immersed in the experience.

Psychological and behavioral treatment can be particularly helpful in such circumstances.

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4. Stress and Mental Overload

The brain is the central organ of sexual experience.

Sexual stimulation may be physically adequate, but a woman who is mentally occupied with:

- work,
- children,
- financial stress,
- family conflict,
- health concerns,
- sleep deprivation,
- or constant worry

may find it difficult to maintain the level of attention and arousal required for orgasm.

This is one reason why sexual problems cannot always be cured by a medicine.

Sometimes reducing mental load is more important than adding another tablet.

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5. Anxiety and Depression

Depression may reduce:

- sexual interest,
- pleasure,
- motivation,
- emotional connection,
- and capacity to experience rewarding sensations.

Anxiety can create:

- excessive self-monitoring,
- fear of failure,
- muscle tension,
- distraction,
- and difficulty surrendering to pleasurable sensations.

ACOG specifically recognizes depression, anxiety and stress as common contributors to sexual difficulties.

Both the condition itself and the medicines used to treat it may influence sexual function.

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6. Antidepressants and Other Medications

Medication history is one of the first things I review when orgasm was previously normal and then suddenly became difficult.

Certain antidepressants, particularly **selective serotonin reuptake inhibitors (SSRIs)**, can cause:

- decreased desire,
- delayed orgasm,
- reduced orgasmic intensity,
- or complete inability to orgasm.

Other medicines can also affect sexual function in some patients.

However, a patient should **never suddenly stop an antidepressant or psychiatric medicine on her own** because withdrawal or relapse may be dangerous.

When medication-induced sexual dysfunction is suspected, the prescribing clinician can consider whether:

- dose adjustment,
- switching medication,
- treatment of contributing symptoms,
- or another strategy

is appropriate.

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7. Relationship Difficulties

Orgasm is not purely mechanical.

Relationship problems can have a major impact.

Common examples include:

- unresolved conflict,
- lack of trust,
- poor communication,
- resentment,
- fear of pregnancy,
- fear of sexually transmitted infection,
- feeling emotionally disconnected,
- sexual pressure,
- insufficient privacy,
- differences in sexual preferences,
- or feeling that one's pleasure is unimportant.

Sometimes the patient does not need a stronger sexual medicine.

The couple needs better communication.

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8. Previous Negative or Traumatic Sexual Experiences

A history of:

- sexual abuse,
- coercion,
- painful first intercourse,
- traumatic sexual experiences,
- or repeated negative messages about sexuality

can influence the nervous system's response to intimacy.

A woman may consciously desire intimacy while another part of her nervous system remains fearful or guarded.

Trauma-informed psychological or psychosexual care may therefore be necessary.

Such patients should never be pressured to "just relax."

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9. Cultural Shame and Sexual Guilt

In some families and communities, girls grow up hearing messages such as:

"A respectable woman should not think about sexual pleasure."

"Female sexual desire is shameful."

"Only men require satisfaction."

A woman may later marry and suddenly be expected to enjoy sexuality without ever having been permitted to understand her own body.

This creates an important contradiction.

As a sexual-health physician, I believe sexual health should be discussed with **dignity, privacy, consent and medical professionalism**.

Female sexual pleasure is not something that should automatically be treated as shameful.

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10. Pain During Intercourse

If intercourse hurts, expecting orgasm may be unrealistic.

Pain can cause the body to enter a protective state instead of a pleasurable state.

Possible causes include:

- vaginal dryness,
- infections,

- vulvodynia,
- vaginismus,
- pelvic-floor muscle problems,
- endometriosis,
- pelvic disease,
- genital skin disorders,
- menopause-related changes,
- and insufficient lubrication or arousal.

Pain must therefore be treated rather than telling the woman simply to “try harder.”

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11. Menopause and Genitourinary Syndrome of Menopause

Around menopause, estrogen levels decline.

This may cause:

- vaginal dryness,
- reduced lubrication,
- thinner vaginal tissue,
- irritation,
- burning,
- painful intercourse,
- and changes affecting the vulva and clitoris.

These symptoms collectively may form part of **genitourinary syndrome of menopause (GSM)**.

If intercourse becomes painful, sexual arousal and orgasm may naturally become more difficult.

Treatment may include:

- vaginal moisturizers,
- appropriate lubricants,
- and, in suitable patients, local vaginal estrogen prescribed after clinical assessment.

ACOG notes that topical vaginal estrogen can effectively improve menopausal vaginal dryness and painful intercourse in appropriate patients.

Hormone therapy should therefore be used for a diagnosed indication—not randomly as an "orgasm medicine."

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12. Pregnancy, Childbirth and Breastfeeding

Female sexual function can change after childbirth.

Possible contributing factors include:

- physical recovery,
- pelvic-floor changes,
- perineal injury,
- vaginal dryness during breastfeeding,
- sleep deprivation,
- fatigue,
- concern about pregnancy,
- body-image changes,
- and the psychological demands of caring for a baby.

Reduced estrogen during breastfeeding can contribute to vaginal dryness in some women.

These changes are often treatable and should not automatically be interpreted as permanent sexual weakness.

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13. Pelvic Surgery or Radiation

Operations or radiation involving the pelvis can occasionally affect:

- genital sensation,
- nerves,
- blood supply,
- pelvic-floor function,
- or sexual confidence.

ACOG specifically identifies pelvic surgery and radiation as potential contributors to orgasmic difficulty.

A newly acquired orgasm problem after pelvic surgery therefore deserves proper clinical assessment.

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14. Neurological Problems

Orgasm requires intact sensory and neurological pathways.

Conditions affecting the brain, spinal cord or peripheral nerves can sometimes interfere with orgasm.

Examples may include:

- spinal cord injury,
- multiple sclerosis,
- peripheral neuropathy,
- certain neurological diseases,
- and nerve injury following surgery.

The treatment depends on the underlying neurological condition.

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15. Diabetes and Metabolic Disease

Long-standing or poorly controlled diabetes can damage nerves and blood vessels.

Although sexual complications of diabetes are discussed more often in men, women can also experience:

- reduced genital sensation,
- reduced lubrication,
- arousal difficulties,
- recurrent genital infections,
- and orgasmic problems.

Good diabetes management is therefore part of sexual-health care.

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16. Pelvic-Floor Dysfunction

The pelvic-floor muscles participate in sexual sensation and orgasmic contractions.

Problems involving these muscles may coexist with:

- pelvic pain,
- painful intercourse,
- urinary symptoms,
- vaginismus,
- or altered sexual sensation.

When pelvic-floor dysfunction is suspected, assessment by a trained pelvic-floor physiotherapist can be useful.

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17. Reduced Genital Sensation

Some women describe:

“I feel touch, but the sensation is not as strong as before.”

Possible contributing factors include:

- nerve injury,
- neurological disease,
- diabetes,
- pelvic surgery,
- menopause,
- medication,
- or age-related changes.

A detailed history is necessary before deciding whether the cause is primarily neurological, hormonal, psychological or mixed.

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18. Relationship Between Desire, Arousal and Orgasm

Orgasm does not occur in isolation.

If desire is absent, arousal may be insufficient.

If arousal is poor, orgasm may become difficult.

If intercourse is painful, arousal may disappear.

If there is severe anxiety, the woman may remain mentally distracted.

Female sexual disorders therefore frequently overlap, which is why a comprehensive assessment is more useful than focusing on a single symptom.

Symptoms of Female Orgasmic Disorder

A woman may report:

- never having experienced an orgasm,
- taking an unusually long time to reach orgasm,
- orgasm occurring only occasionally,
- markedly reduced orgasm intensity,
- inability to orgasm during intercourse,
- ability to orgasm alone but not with a partner,
- loss of orgasm after previously normal sexual function,
- frustration during sexual activity,
- reduced interest in sex because orgasm seems impossible,
- anxiety before intimacy,
- relationship tension,
- or reduced sexual satisfaction.

However, the diagnosis depends not only on what happens physically but also on whether the problem is **persistent and personally distressing**.

Is It Normal Not to Reach Orgasm Every Time?

Yes.

A woman does not have to reach orgasm during every sexual encounter for her sexual life to be considered normal.

Sexual satisfaction can involve:

- affection,
- emotional intimacy,
- pleasure,

- relaxation,
- closeness,
- arousal,
- and orgasm.

ACOG specifically notes that some people are satisfied with intimacy even without orgasm, while others find the absence of orgasm distressing.

Therefore, medicine should focus on the woman's own experience—not on a rigid performance standard.

Does Penetration Alone Have to Produce Orgasm?

No.

This is one of the most important myths I want to correct.

Many women require direct or indirect clitoral stimulation.

Therefore, inability to orgasm from penetration alone does **not** automatically indicate female sexual dysfunction.

The recent 2026 clinical literature emphasizes the central anatomical importance of the clitoris in female orgasmic function.

Understanding this can remove enormous unnecessary anxiety from couples.

Does Absent Orgasm Cause Female Infertility?

No. A woman does not need to experience orgasm in order to become pregnant.

This is another important misconception.

Pregnancy primarily requires:

- ovulation,
- viable sperm,
- appropriate sperm transport,
- functional reproductive anatomy,
- fertilization,
- and successful implantation.

Female orgasm is not required for fertilization.

Therefore, a woman can experience anorgasmia and still conceive naturally.

However, orgasmic difficulties may coexist with reproductive problems because conditions such as:

- hormonal disorders,
- sexual pain,
- relationship difficulty,
- inability to consummate marriage,
- or severe sexual anxiety

may indirectly affect the couple's ability or willingness to have intercourse.

At **Saira Health Care**, because my focused practice includes sexual disorders and infertility, I distinguish carefully between:

sexual function

and

fertility.

They are related areas of reproductive health, but they are not the same thing.

How I Diagnose Absent Female Orgasm

There is no single blood test for anorgasmia.

Diagnosis begins with careful, respectful conversation.

Step 1: Understand the Exact Problem

I may ask:

- Have you ever experienced orgasm?
- Did the problem begin recently?
- Can you orgasm during self-stimulation?
- Can you orgasm with a partner?
- Is the problem present every time or only sometimes?
- Has orgasm become weaker than before?

- Do you experience adequate sexual desire?
- Do you become physically aroused?
- Is intercourse painful?
- Is vaginal dryness present?
- What type of stimulation is being used?
- How long does stimulation usually continue?
- Are you under pressure to reach orgasm quickly?

These questions are medical questions.

They should be asked without embarrassment or judgement.

Step 2: Medication Review

I ask about:

- antidepressants,
- psychiatric medicines,
- hormonal medicines,
- contraceptive medicines,
- sedatives,
- and other prescription or non-prescription products.

Medication review is particularly important when orgasmic difficulty begins after starting or changing treatment.

Step 3: Medical History

Relevant conditions may include:

- diabetes,
- thyroid disease,
- neurological disorders,
- pelvic surgery,
- cancer treatment,

- chronic pain,
- depression,
- anxiety,
- menopausal symptoms,
- and other endocrine or gynecological disorders.

Step 4: Menstrual and Reproductive History

I may ask about:

- menstrual-cycle regularity,
- pregnancy history,
- childbirth,
- breastfeeding,
- menopause,
- fertility concerns,
- pelvic pain,
- vaginal dryness,
- and previous reproductive treatment.

This becomes particularly important when the sexual complaint occurs together with infertility or hormonal symptoms.

Step 5: Psychological and Relationship Assessment

A good sexual-history assessment also explores:

- stress,
- anxiety,
- depression,
- body image,
- fear,
- sexual trauma,

- relationship satisfaction,
- communication,
- privacy,
- cultural beliefs,
- and sexual expectations.

A 2024 medical review emphasizes that evaluation should include **sexological, medical and psychological history** and that treatment often benefits from cognitive and behavioral approaches.

Step 6: Physical Examination When Indicated

Not every patient with orgasmic difficulty requires an extensive pelvic examination.

However, examination may be useful when there is:

- genital pain,
- abnormal sensation,
- pelvic-floor dysfunction,
- menopause-related symptoms,
- suspected anatomical abnormality,
- vulvar disease,
- or another gynecological concern.

Recent clinical literature recommends that assessment, when indicated, pay attention to genital anatomy—including the clitoris—and pelvic-floor function.

Step 7: Laboratory Tests When Indicated

There is no routine “orgasm hormone panel” that every woman needs.

Laboratory testing should be guided by symptoms.

Depending on the clinical picture, selected tests may investigate:

- thyroid function,
- diabetes,
- reproductive hormones,

- anemia or nutritional issues,
- or other suspected medical causes.

Testing without a clinical reason may create confusion rather than clarity.

Treatment of Absent Female Orgasm

There is no single universal treatment.

A woman with lifelong anorgasmia, another with antidepressant-induced delayed orgasm and a third with painful menopausal intercourse require completely different approaches.

Modern reviews consistently recommend **individualized biopsychosocial treatment**.

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1. Sexual Education

Education is often the beginning of treatment.

Women and couples may need to understand:

- the role of the clitoris,
- the difference between desire and arousal,
- the importance of sufficient stimulation,
- normal variation in orgasm,
- and the fact that penetration alone does not guarantee orgasm.

Removing unrealistic expectations can itself improve sexual response.

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2. Directed Self-Stimulation

One of the best-supported approaches for female orgasmic disorder is **directed masturbation or structured self-stimulation**.

The goal is therapeutic, not simply recreational.

A woman gradually learns:

- which touch feels pleasurable,
- what pressure she prefers,
- what rhythm works,
- whether direct or indirect clitoral stimulation is more comfortable,

- and what psychological conditions help her relax.

The MSD Manual lists directed self-stimulation among the first-line treatments for female orgasmic disorder.

Once a woman understands her own response, communication with a partner becomes easier.

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3. Increasing Appropriate Stimulation

Some patients simply need:

- more time,
- more variety,
- better communication,
- direct clitoral stimulation,
- less pressure,
- and greater emotional comfort.

A sexual encounter should not be treated like an examination that must be passed.

The goal is pleasurable experience rather than chasing an orgasm mechanically.

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4. Vibratory Stimulation

A vibrator can provide consistent genital stimulation and may be useful for some women.

Clinical guidance recognizes vibratory stimulation as one possible aid for orgasmic difficulty.

It is especially useful when a woman requires stronger or more consistent stimulation than manual stimulation provides.

There should be no shame attached to using an appropriate sexual-health device when clinically suitable.

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5. Sensate Focus

Sensate-focus exercises are commonly used in sex therapy.

Instead of making intercourse or orgasm the immediate target, partners gradually focus on:

- comfortable touch,

- bodily sensations,
- communication,
- relaxation,
- and pleasurable physical connection.

Performance pressure is gradually reduced.

This can be particularly helpful when anxiety is maintaining the problem.

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6. Cognitive Behavioral Therapy

Cognitive behavioral therapy may help a woman identify thoughts such as:

- “I must orgasm.”
- “My body is defective.”
- “My partner will be disappointed.”
- “A good wife should automatically know how to respond.”
- “Sexual pleasure is wrong.”

These beliefs may generate anxiety that interferes with sexual response.

CBT and other psychological approaches are included among established treatment strategies for female orgasmic disorder.

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7. Mindfulness-Based Therapy

Mindfulness encourages attention to:

- physical sensation,
- breathing,
- touch,
- pleasure,
- and the present moment

without constantly judging whether orgasm is “about to happen.”

The MSD Manual recognizes mindfulness-based cognitive approaches as potentially useful because they help women remain attentive to sexual sensations instead of monitoring themselves critically.

8. Couple or Sex Therapy

When communication or relationship dynamics contribute to the difficulty, therapy involving both partners can be very valuable.

Topics may include:

- sexual preferences,
- expectations,
- stimulation,
- emotional intimacy,
- frequency of sex,
- performance pressure,
- unresolved conflict,
- and differences in desire.

A partner should become part of the solution rather than another source of pressure.

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9. Treatment of Painful Intercourse

If sex is painful, treating the pain becomes a priority.

Depending on the cause, management may involve:

- lubricants,
- vaginal moisturizers,
- treatment of infection,
- pelvic-floor physiotherapy,
- treatment of vulvar conditions,
- management of vaginismus,
- treatment of endometriosis or pelvic disease,
- or menopausal therapy.

ACOG recommends addressing dryness and pain directly rather than ignoring them as part of sexual dysfunction.

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10. Treatment of Menopausal Vaginal Dryness

When genitourinary syndrome of menopause contributes to painful or uncomfortable sex, treatment may significantly improve sexual comfort.

Options may include:

- vaginal moisturizers,
- lubricants,
- and local vaginal estrogen where medically appropriate.

Topical estrogen is aimed primarily at correcting menopausal vulvovaginal symptoms rather than acting as a direct “orgasm drug.”

This distinction is important.

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11. Pelvic-Floor Physiotherapy

Women with pelvic-floor dysfunction may benefit from specialist physiotherapy.

Treatment can include:

- pelvic-floor awareness,
- relaxation,
- strengthening when appropriate,
- biofeedback,
- and management of painful muscle overactivity.

The exact programme depends on whether the muscles are excessively tense, weak or poorly coordinated.

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12. Review Medication-Related Sexual Dysfunction

If the problem began after starting an antidepressant or another medication, treatment may involve discussion with the prescribing doctor.

Never discontinue psychiatric medication without medical supervision.

A clinician may sometimes consider:

- adjusting dose,
- changing medication,

- modifying timing,
- or treating contributing symptoms.

The correct choice depends on the patient's psychiatric and medical history.

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13. Treat Underlying Medical Conditions

When orgasmic dysfunction is secondary to:

- uncontrolled diabetes,
- neurological disease,
- depression,
- thyroid disease,
- chronic pain,
- or another medical condition,

management of the primary illness becomes part of sexual treatment.

Are There Medicines Specifically Approved for Female Orgasmic Disorder?

At present, **there is no medication specifically approved for the treatment of female orgasmic disorder itself**.

A 2024 review states that no pharmacological treatment is approved specifically for female orgasmic disorders, while current treatment relies primarily on appropriate psychological, cognitive, behavioral and individualized interventions.

A recent 2026 review likewise notes the absence of an FDA-approved drug specifically for female orgasmic disorder.

This is important because patients encounter advertisements promising:

“One capsule will guarantee female climax.”

Such claims should be approached cautiously.

Sexual function is too complex to reduce to one universal drug.

What About Sildenafil, Bupropion or Hormones?

Various medicines have been studied or used off-label in selected circumstances.

However:

- evidence is variable,
- treatment is not appropriate for everyone,
- and none should be self-prescribed as a universal female orgasm treatment.

Hormonal therapy may be useful when there is a specific hormonal indication—for example menopausal vaginal symptoms—but that is different from prescribing hormones simply because orgasm is absent.

A qualified physician should determine whether pharmacological treatment has a genuine role.

What About PRP, "O-Shot," Laser and Other New Treatments?

Patients increasingly encounter advertisements for:

- platelet-rich plasma injections,
- "O-Shot" procedures,
- vaginal laser treatments,
- regenerative injections,
- stem-cell approaches,
- and other procedures marketed for sexual enhancement.

Some remain areas of research.

A 2025 review described regenerative techniques as emerging approaches rather than established routine therapy.

Patients should therefore ask:

- What is the scientific evidence?
- Is the treatment approved for this indication?
- What are the known risks?
- How many controlled trials exist?
- Is the claimed benefit specific to orgasmic disorder?

An expensive treatment is not automatically an effective treatment.

Understanding Absent Female Orgasm in the Unani System of Medicine

Unani medicine views health through a broad relationship between:

- physical constitution,
- temperament or **Mizaj**,
- bodily functions,
- mental state,
- nutrition,
- sleep,
- physical activity,
- and environmental influences.

Classical Unani theory describes four humors—**Dam, Balgham, Safra and Sauda**—and traditionally interprets illness through disturbances in temperament, humoral balance and organ function.

It is important to understand that this is a **traditional medical framework** and should not be confused with the biological mechanisms used in modern neuroscience or endocrinology.

The Ministry of AYUSH describes Unani medicine as a system that gives importance to the psychosomatic relationship between body and mind and uses individualized assessment of constitution and lifestyle.

This mind-body orientation is particularly relevant to sexual medicine because female orgasm itself is strongly influenced by psychological as well as physical factors.

The Six Essential Factors in Unani Medicine

A central concept in Unani health preservation is **Asbab-e-Sitta Zarooriya**, or the six essential factors.

These broadly include:

1. **Air and environment**
2. **Food and drink**
3. **Physical activity and rest**
4. **Mental and emotional activity and rest**
5. **Sleep and wakefulness**

6. **Retention and elimination**

The Ministry of AYUSH continues to describe these principles as fundamental to traditional Unani health maintenance.

In sexual-health practice, I find this framework useful because sexual function can be affected by many of these same lifestyle domains.

For example:

- chronic sleep deprivation may reduce sexual energy,
- severe psychological stress may interfere with arousal,
- poor health can impair sexual well-being,
- relationship strain can disrupt emotional relaxation,
- and uncontrolled metabolic disease can affect nerve and vascular health.

Four Major Therapeutic Approaches in Unani Medicine

Official AYUSH descriptions identify four broad therapeutic approaches in Unani medicine:

1. Ilaj-bil-Ghiza

Dietotherapy

2. Ilaj-bit-Tadbir

Regimenal therapy

3. Ilaj-bid-Dawa

Pharmacotherapy

4. Ilaj-bil-Yad

Surgical treatment

For female orgasmic difficulty, the most relevant areas are generally diet and lifestyle optimization, psychological support, individualized treatment of contributing conditions, and carefully selected pharmacotherapy when appropriate.

How Unani Medicine Can Be Useful in Female Orgasmic Difficulty

I do not believe responsible Unani medicine should promise:

“Take this herb and every woman will experience orgasm.”

That would oversimplify the problem.

Instead, Unani medicine may be particularly useful as part of an **individualized integrative programme** addressing factors such as:

- general weakness or poor nutritional health,
- disturbed sleep,
- excessive stress,
- digestive or metabolic health,
- physical inactivity,
- psychological tension,
- reproductive well-being,
- and overall lifestyle balance.

The strength of the Unani approach is its emphasis on treating the individual rather than treating one isolated symptom.

But where there is:

- severe depression,
- trauma,
- neurological disease,
- medication-induced dysfunction,
- menopausal vaginal atrophy,
- genital pain,
- pelvic-floor disease,
- or another specific medical cause,

that underlying problem must also be recognized and treated appropriately.

Ilaj-bil-Ghiza: Dietotherapy

Good sexual health cannot be separated from general health.

My dietary advice depends on:

- age,

- body weight,
- nutritional status,
- diabetes,
- digestive health,
- reproductive status,
- menopause,
- activity level,
- and other diseases.

A balanced diet generally emphasizes:

- adequate protein,
- vegetables,
- fruits,
- whole grains,
- healthy fats,
- nuts and seeds,
- hydration,
- and sufficient vitamins and minerals.

The goal is not to label one food as a “female Viagra.”

The goal is to maintain healthy neurological, metabolic, hormonal and vascular function.

Ilaj-bit-Tadbir: Regimenal and Lifestyle Management

Depending on the individual, lifestyle management may include:

- regular physical activity,
- adequate sleep,
- stress reduction,
- relaxation,
- healthy body weight,
- reduction of excessive mental strain,

- and appropriate therapeutic regimens.

Unani medicine traditionally emphasizes both physical and psychological balance, which makes lifestyle assessment particularly relevant in psychosexual disorders.

Mental and Emotional Health in Unani Treatment

I consider this one of the most important areas where traditional holistic thinking and modern sexual medicine can complement each other.

A woman may have normal reproductive anatomy but still experience orgasmic difficulty because of:

- anxiety,
- fear,
- resentment,
- guilt,
- depression,
- or trauma.

Medication alone may not resolve these problems.

Therefore, psychological counselling, behavioral therapy, partner communication and stress management may be combined with appropriately selected Unani supportive care.

Herbal Medicines: What Does the Evidence Actually Show?

Herbal treatment is commonly discussed in relation to sexual health.

Some traditional preparations may contain herbs such as:

- saffron,
- ginger,
- fenugreek,
- and other plant-derived ingredients.

However, traditional use and modern clinical proof are not the same thing.

For example, saffron has been studied in a small randomized placebo-controlled trial involving women with **fluoxetine-induced sexual dysfunction**.

Interestingly, although saffron improved some overall sexual-function measures—particularly arousal and lubrication—the study did **not find a statistically significant improvement specifically in the orgasm domain**.

This finding is important.

It demonstrates why I prefer not to tell patients:

"Saffron is scientifically proven to cure absent orgasm."

The evidence does not support such a sweeping claim.

Herbs may still have traditional roles, but their:

- indication,
- dose,
- formulation,
- safety,
- interactions,
- and suitability

must be assessed individually.

Why "Natural" Does Not Mean "Use Without Supervision"

A woman may be taking:

- antidepressants,
- thyroid medicines,
- diabetes medicines,
- fertility treatment,
- contraceptives,
- anticoagulants,
- hormonal therapy,
- or other medicines.

Adding concentrated herbal products without informing the treating physician may create unwanted interactions or side effects.

Therefore, even Unani medicines should be used thoughtfully and professionally.

Dr. Nizamuddin Qasmi's Individualized Approach to Absent Female Orgasm

At **Saira Health Care**, I do not approach female orgasmic disorder with a fixed packet or one universal medicine.

I generally think through the case in the following sequence.

Step 1: Identify the Type of Orgasmic Difficulty

Is it:

- lifelong or acquired?
- generalized or situational?
- complete absence or only delay?
- reduced intensity?
- present only with intercourse?
- absent even during self-stimulation?

This distinction immediately tells us a great deal.

Step 2: Separate Desire, Arousal, Orgasm and Pain

I determine whether the main problem is genuinely orgasm.

Sometimes a patient says:

“I cannot climax.”

But deeper questioning reveals severe painful intercourse.

Another patient actually has very low sexual desire.

Another cannot become sufficiently aroused.

Another has good arousal but cannot cross the final orgasmic threshold.

Each requires different treatment.

Step 3: Review Medication

If sexual function changed after a medicine was started, medication-related dysfunction must be considered.

This is especially important with certain antidepressants.

I do not advise patients to discontinue necessary medicines independently.

Instead, the problem should be discussed with the prescribing clinician.

Step 4: Look for Physical Causes

Where indicated, I evaluate or arrange evaluation for:

- diabetes,
- thyroid dysfunction,
- menopausal symptoms,
- pelvic pain,
- vaginal dryness,
- neurological disease,
- pelvic-floor dysfunction,
- and other relevant conditions.

Step 5: Understand the Psychological Environment

I ask about:

- stress,
- depression,
- anxiety,
- fear,
- previous trauma,
- sexual guilt,
- relationship tension,
- and performance pressure.

This part of treatment must remain confidential and non-judgmental.

Step 6: Educate About Female Sexual Anatomy

Many women have never been properly taught about:

- the clitoris,
- sexual arousal,
- stimulation,
- normal orgasmic variation,
- and the difference between penetration and orgasm.

Correct education can sometimes be more useful than another medicine.

Step 7: Improve Sexual Communication

A woman must be able to communicate:

- what feels comfortable,
- what feels pleasurable,
- when stimulation needs to continue,
- when pressure is excessive,
- and what causes pain or anxiety.

A caring partner should not interpret guidance as criticism.

Good sexual communication is a clinical tool.

Step 8: Introduce Evidence-Based Behavioral Strategies

Depending on the patient, this may include:

- directed self-stimulation,
- gradual sensory exploration,
- sensate-focus exercises,
- mindfulness,
- appropriate clitoral stimulation,
- reducing performance pressure,
- and couple-based interventions.

These approaches are supported more consistently than any universal medication for orgasmic disorder.

Step 9: Integrate Unani Lifestyle and Supportive Treatment

Where appropriate, I incorporate:

- Ilaj-bil-Ghiza,
- lifestyle correction,
- healthy sleep,
- physical activity,
- stress reduction,
- individual Mizaj assessment,
- and selected Unani pharmacotherapy when clinically suitable.

Traditional treatment should support the patient—it should not replace necessary diagnosis.

Step 10: Refer When Necessary

An important part of being a responsible physician is recognizing when another specialist is needed.

Depending on the cause, referral may be appropriate to a:

- gynecologist,
- endocrinologist,
- neurologist,
- psychiatrist,
- psychologist,
- psychosexual therapist,
- pelvic-floor physiotherapist,
- or other specialist.

Integrative medicine works best when it does not create artificial barriers between specialties.

What I Do Not Promise My Patients

In sexual medicine, dramatic promises can be particularly harmful.

I do not believe it is medically responsible to tell every woman:

“One medicine will make you climax every time.”

I also do not promise:

- instant cure,
- guaranteed orgasm within a fixed number of days,
- permanent cure from one herbal product,
- or identical results for every patient.

The causes of orgasmic dysfunction are too diverse.

Successful treatment means identifying **why this particular woman** is experiencing difficulty and addressing those factors systematically.

What Does Successful Treatment Look Like?

Success does not necessarily mean exactly the same thing for every patient.

Patient pattern 1

A woman who has never experienced orgasm may gradually understand her anatomy, discover effective stimulation and experience her first orgasm.

Patient pattern 2

A woman who can orgasm alone but not with her husband may improve through communication, clitoral stimulation and reduction of performance pressure.

Patient pattern 3

A woman whose orgasm disappeared after starting an antidepressant may improve after her psychiatric treatment is appropriately reviewed.

Patient pattern 4

A menopausal woman may discover that painful dryness is preventing arousal; treating her genitourinary symptoms may make intimacy comfortable again.

Patient pattern 5

A woman with sexual trauma may benefit most from trauma-informed psychological treatment rather than aphrodisiac medicine.

Patient pattern 6

A woman convinced that she is “abnormal” may discover that her sexual response is within the broad range of normal variation.

All of these can represent successful treatment.

For this reason, Saira Health Care should publish only genuine, consented and properly documented patient outcomes rather than invented before-and-after “success stories.”

Role of the Partner

I often tell couples:

Female orgasm should not become the husband's examination result.

When a man becomes excessively focused on:

“Did you climax?”

the question itself can increase pressure.

A better approach is to focus on:

- comfort,
- affection,
- communication,
- pleasure,
- adequate stimulation,
- patience,
- and emotional security.

The partner can help by:

- listening,
- avoiding criticism,
- allowing sufficient time,
- learning what type of stimulation the woman prefers,
- and understanding that sexual response varies from day to day.

Common Myths About Female Orgasm

Myth 1: Every woman should orgasm from penetration.

Fact: Many women require clitoral stimulation.

Myth 2: A woman who cannot orgasm is infertile.

Fact: Orgasm is not required for pregnancy.

Myth 3: No orgasm means she does not love her partner.

Fact: Orgasm is influenced by many neurological, medical, psychological and stimulation-related factors.

Myth 4: If the husband lasts longer, the woman will definitely orgasm.

Fact: Duration alone does not guarantee appropriate stimulation.

Myth 5: A woman who enjoys self-stimulation has a disease.

Fact: Self-exploration can help a woman understand how her sexual response works and is even used therapeutically in orgasmic disorder.

Myth 6: Low estrogen causes every female orgasm problem.

Fact: Hormonal changes can contribute in some women, but psychological, neurological, medication, relationship and stimulation factors are also important.

Myth 7: Herbal aphrodisiacs always cure the problem safely.

Fact: Evidence varies significantly between products and herbs, and even “natural” products require appropriate clinical supervision.

Frequently Asked Questions

Is female anorgasmia common?

Yes. Orgasmic difficulties are common and underreported.

A 2026 review estimates female orgasmic disorder in approximately 10–28% of women, although prevalence varies according to definitions and study populations.

Does every woman need orgasm during every sexual encounter?

No.

Normal female sexual response varies significantly.

A disorder is more likely when orgasmic difficulty is persistent and causes meaningful personal distress.

Can a woman have desire but no orgasm?

Yes.

Desire, arousal and orgasm are different components of sexual response.

Can a woman orgasm during masturbation but not intercourse?

Yes.

This is relatively common and often suggests that stimulation, communication, anxiety or sexual context may be important.

It does not automatically mean she has a hormonal disease.

Is clitoral stimulation important?

For many women, yes.

The clitoris is a central anatomical structure in female orgasmic response.

Can antidepressants delay orgasm?

Yes.

Some antidepressants can interfere with desire, arousal and orgasm.

Do not stop them independently; discuss sexual side effects with the prescribing clinician.

Can menopause cause orgasm problems?

Menopause can contribute indirectly or directly through:

- vaginal dryness,
- painful intercourse,
- reduced genital comfort,
- hormonal changes,
- sleep disturbance,
- and other factors.

Genitourinary syndrome of menopause is treatable.

Does absent orgasm affect pregnancy?

Not directly.

Female orgasm is not required for fertilization.

Can Unani medicine help?

Unani medicine can be useful as part of an individualized, holistic programme addressing:

- nutrition,
- lifestyle,
- sleep,
- stress,
- general health,
- reproductive wellness,
- and selected contributing conditions.

However, treatment should be integrated with appropriate sexual education, psychological therapy, medical evaluation and specialist care according to the actual cause.

Is saffron proven to cure female anorgasmia?

No.

A small randomized study found some improvement in sexual-function measures among women with fluoxetine-associated sexual dysfunction, but it did **not demonstrate a statistically significant benefit in the orgasm domain**.

Therefore, saffron should not be advertised as a scientifically proven cure for anorgasmia.

Is there a female version of Viagra for orgasm?

There is currently no medication specifically approved as a universal treatment for female orgasmic disorder.

Treatment depends on the cause.

When Should a Woman Seek Professional Help?

Consider consultation when:

- you have never experienced orgasm and this causes distress,
- you previously experienced orgasm but can no longer do so,
- orgasm has become much weaker,
- sexual difficulty continues for months,
- the problem is affecting your relationship,
- intercourse is painful,
- vaginal dryness is significant,
- there has been a recent medication change,
- you have diabetes or neurological disease,
- the problem developed after pelvic surgery,
- depression or anxiety is severe,
- past sexual trauma is affecting intimacy,
- or you simply need confidential guidance about your sexual response.

You do not need to wait until the problem becomes severe before seeking help.

Dr. Nizamuddin Qasmi and Saira Health Care

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with focused clinical work in **sexual disorders and infertility**.

My professional education and training listed for this clinical work 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**

Saira Health Care's public physician profile lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK, and describes my focused work in sexual disorders and infertility.

MasterHealthPro currently lists its **Male Infertility Masters** as a six-month educational programme covering male infertility and sexual dysfunction, with female sexual dysfunction among the areas included in its curriculum.

My interest in sexual medicine is therefore not limited to prescribing medicines.

It involves understanding how:

- reproductive health,
- fertility,
- sexual function,
- psychological health,
- relationships,
- hormonal conditions,
- and lifestyle

interact with one another.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Sexual-health problems are among the most misunderstood conditions in healthcare.

Many patients delay seeking help because they fear:

- embarrassment,
- judgement,
- social stigma,
- breach of privacy,
- or being told their problem is imaginary.

At Saira Health Care, one of our important goals is to make sexual-health consultation **confidential, respectful and medically meaningful**.

Our broader clinical approach includes:

- detailed history,
- appropriate reproductive and sexual assessment,
- patient education,
- modern investigations when indicated,
- evaluation of fertility concerns,
- lifestyle correction,
- individualized Unani treatment where appropriate,
- psychological and relationship guidance,
- and specialist referral when necessary.

Saira Health Care's current public material identifies sexual disorders and infertility as central areas of Dr. Nizamuddin Qasmi's clinical focus.

My Integrative Philosophy

I do not believe modern medicine and Unani medicine need to be presented as enemies.

The best patient care asks:

What does this particular patient actually need?

A woman with:

- medication-induced dysfunction

needs medication review.

A woman with:

- severe anxiety

may need psychological care.

A woman with:

- inadequate sexual stimulation

needs education and behavioral intervention.

A woman with:

- painful menopausal dryness

needs treatment for the dryness.

A woman with:

- poor lifestyle and general health

may benefit from diet and lifestyle optimization.

A woman with:

- pelvic-floor dysfunction

may benefit from physiotherapy.

And where individualized Unani therapy is clinically appropriate, it can be incorporated responsibly.

This is the approach I consider genuine integrative medicine.

Final Message to Women

If you are unable to reach orgasm, please do not immediately conclude:

“I am sexually weak.”

And please do not believe:

“I am not a normal woman.”

Instead, ask:

“What is preventing my sexual response from progressing normally?”

The answer may involve:

- stimulation,
- psychology,

- medication,
- pain,
- hormones,
- nerves,
- pelvic-floor health,
- relationship factors,
- or several of these together.

Female orgasm is a complex neurobiological and psychological process.

It deserves careful assessment—not shame.

At **Saira Health Care**, my aim is to provide an environment where women and couples can discuss these intimate concerns respectfully and receive an individualized treatment plan.

I believe the most effective sexual-health treatment begins with three things:

accurate diagnosis, honest education and patient-centered care.

When Unani medicine is used, I believe it should follow the same principle: traditional knowledge should be applied thoughtfully, safely and according to the individual's overall condition while modern diagnostic information and evidence-based therapies are incorporated whenever necessary.

Conclusion

Absent female orgasm, medically referred to as **female orgasmic disorder or anorgasmia**, is a multifactorial sexual-health concern.

It may be:

- lifelong or acquired,
- generalized or situational,
- completely absent,
- delayed,
- infrequent,
- or reduced in intensity.

The causes may include inadequate stimulation, lack of sexual education, psychological stress, anxiety, depression, relationship difficulties, trauma, medication side effects, painful

intercourse, menopause, pelvic-floor dysfunction, neurological disease, diabetes, pelvic surgery and other medical conditions.

Proper treatment therefore requires more than prescribing an aphrodisiac.

Current medical evidence supports a biopsychosocial approach involving:

- sexual education,
- appropriate clitoral and genital stimulation,
- directed self-stimulation,
- behavioral strategies,
- cognitive therapy,
- mindfulness,
- sex or couple therapy,
- treatment of pain and vaginal dryness,
- pelvic-floor therapy,
- medication review,
- and treatment of underlying medical conditions.

No medication is currently approved specifically as a universal treatment for female orgasmic disorder.

The **Unani system of medicine** can make a valuable supportive contribution through its individualized attention to diet, lifestyle, sleep, psychological well-being, physical activity, general health and selected traditional pharmacotherapy. Its holistic philosophy is particularly relevant to sexual disorders because sexual function is closely connected with both body and mind.

However, Unani treatment should never be used to make unsupported guarantees or to delay necessary gynecological, neurological, psychological or medical care.

My approach at **Saira Health Care** is therefore:

Understand the woman as a whole.
Identify the true cause.
Correct reversible factors.
Use Unani care responsibly.
Integrate modern diagnosis where necessary.
Treat with dignity and confidentiality.
And never promise what medical science cannot guarantee.

That, in my view, is the correct way to approach female sexual health.

About the Author

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional Education & Training

- BUMS – Hamdard University, Delhi
- MD
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Saira Health Care's official physician profile identifies Dr. Nizamuddin Qasmi's principal clinical focus as sexual disorders and infertility and lists BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK among his qualifications.

Medical Disclaimer

This article is intended for patient education and general health information.

It should not be used as a substitute for an individual medical consultation, diagnosis, psychological assessment or treatment plan.

Female sexual difficulties can result from medical, hormonal, neurological, psychological, medication-related and relationship factors. Treatment therefore needs to be individualized.

Do not stop antidepressants, hormonal medicines or other prescription drugs because of sexual side effects without discussing the matter with the prescribing clinician.

Unani medicines and herbal preparations should also be used under qualified professional supervision. “Natural” treatment does not automatically mean that a medicine is appropriate or free from adverse effects.

Patients with severe genital or pelvic pain, unexplained bleeding, neurological symptoms, significant depression, trauma-related symptoms or another concerning medical problem should receive appropriate specialist evaluation.