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“Standard Operating Procedures for Female Orgasmic Disorder” is not Based on Best Evidence

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Given the authoritative-sounding title, the recent *JSM* article “Standard Operating Procedures for Female Orgasmic Disorder: Consensus of the International Society for Sexual Medicine” [1] might be assumed by many readers to reflect the available evidence on that topic. Many readers might also assume that there is no need to read far beyond the literature presented, and might assume that to practice otherwise risks not using standard operating procedure for female orgasmic disorder (FOD). Some readers who are aware of problems with the approach taken and the prescribed recommendations might be intimidated into silence and compliance.

Unfortunately, that article was definitely not based on the best evidence, and thus risks harming women’s health. A few of the omissions and misrepresentations are detailed here, along with references providing evidence to the contrary of the assertions of Laan et al. [1].

The authors assigned themselves “Grade A” evidence for the claim that “FOD should not be diagnosed solely on the basis of a failure to experience orgasm during sexual intercourse in the absence of additional clitoral stimulation, as this is considered a ‘normal variation of sexual response’ rather than a ‘pathological inhibition,’ ” (p. 75) and referenced two sources that used nonrepresentative samples to support the claim that women’s intercourse orgasm was not common. In contrast, in large nationally representative samples, it was observed that the clear majority of women have had vaginal orgasm (orgasm triggered by penile–vaginal intercourse without the need for concurrent clitoral masturbation by either partner) [2–4]. In addition, in the nonrepresentative but influential Kinsey data, about 50% of women having intercourse (albeit with no specification of with or without clitoral masturbation) for 1–11 minutes had an orgasm on 90–100% of occasions, increasing to 61.6% in the 12- to 15-minute intercourse group, and 66.7% in the >15-minute intercourse group [5,6]. Furthermore, in a report on a psychophysiological study in Laan’s laboratory, it was noted that “Of the women engaging in the activity during the recording period, 38.5% reported having an orgasm during 100% of intercourses (7.7% during 75%, 23.1% during 50%, and 15.4% during 25%)” [7] (p. 20), and the proportions did not differ from other sexual behavior triggers of orgasm.

In section 2 of the Laan et al. article [1], it was asserted that “In general, women seem relatively unaware of their own genital changes, particularly at the early stages of sexual response, and therefore may lack the proprioceptive feedback that could further increase their arousal” [1] (p. 75). Of note, studies conducted in Laan’s laboratory [7,8] indicated that women who had greater intercourse orgasm consistency (but not greater orgasm consistency from other sexual behaviors) had excellent concordance of subjective and vaginal responses. These findings, together with those showing that self-reported lack of attention to vaginal sensations can reduce the capacity to attain intercourse orgasm [4], suggest that the putative lack of proprioceptive feedback of vaginal sensations might be a sign of distraction from sexual sensations in women with difficulties in attaining intercourse orgasm. Quite properly, Laan et al. [1] acknowledged that lack of focusing attention on sexual cues is a risk factor for orgasmic dysfunction, but they seemed to dismiss the cues from the vagina itself.

Laan et al. [1] rightly noted that lack of adequate stimulation by partners with erectile dysfunction and premature ejaculation may lead to women’s complaints of orgasmic failure. However, they failed to note that such male difficulties are particularly relevant for women’s intercourse orgasm [4,6,9].

In section 3, the authors assigned a “Grade A” to their claim that “The presence of distress (or worry/bother) associated with the lack of, or difficulties with, orgasm is a necessary aspect of the FOD diagnosis that needs to be explicitly elicited and not implied” (p. 76). In providing a basis for such an argument, they cited two studies noting that distress was present in about half of orgasm difficulty cases. One study found that 85% of women with arousal or orgasm problems reported being satisfied with their sexual relationship. However, Laan et al. failed [1] to note that the sample was composed of “100 well educated and happily married couples,” that it was not clarified if the problems would qualify for a diagnosis, and that the number of sexual difficulties was indeed related to overall sexual dissatisfaction [10]). The second cited study actually indicated that women’s orgasm was important to their sexual satisfaction. The authors’ citations did not provide evidence for the exceptionalism that some wish to apply to sexual disorders (and almost no other form of disorder), in which a

disorder does not exist if distress is denied. Indeed, rather than being an index of clinical significance, distress might be “an enduring blend of anxiety and depression that approximates a disorder in itself” [11] (p. 3385) (see also [12,13]). It should also be noted that sexual disorders with and without distress have differing correlates, including that female sexual arousal disorder with distress (but not without distress) was associated with never having vaginal orgasm (and the disorder was associated with having frequent anal intercourse) [11]. A recent *JSM* review of the issue of requiring distress in the diagnosis of sexual dysfunctions concluded that it was essentially a philosophical issue, rather than clearly a scientific one [14]. The authors of that review reasonably suggested further research on the issue.

The greatest deviation from best evidence is Laan et al. [1] having assigned themselves a “Grade A” for the claims made in section 4, beginning “The view that clitoral and vaginal orgasms are distinct phenomena appears to be outdated. Evidence suggests that the ‘clitoral complex’ is also stimulated during vaginal penetration” (p. 76). In so stating, they referred to some evidence [15] that the penis has the potential to stimulate the clitoris (either directly or through stimulation of adjacent structures including perhaps through the anterior vaginal wall). However, these findings do not argue for a lack of physiological difference between vaginal and clitoral orgasms. Given that the full length of the vaginal walls and cervix are well innervated [16], and that the clitoris, vagina, and cervix have different afferent pathways and sensory cortex projections [17], it is logical that, whatever stimulation might be occurring in the nominal “clitoral complex,” there are physiological (and psychological) differences between orgasm attained by the penile stimulation of the vagina without resorting to clitoral masturbation (vaginal orgasm) and orgasm dependent upon the masturbatory manipulation of the clitoral glans. Although some might attempt to allocate “G-spot” (corresponding roughly to the vagina region stimulated in the Komisaruk et al. brain imaging study) erotic qualities and orgasm to the nominal “clitoral complex,” the brain imaging evidence [17], as well as the presence of other structures (exocrine glands, muscles, and other nerves in the anterior vaginal wall [18]) speak to sensory processes independent of the clitoris in the lower vagina. It has also been observed that clitoral orgasm leads to the vagina ballooning outwards, but G-spot orgasm results in the cervix moving down into the vagina [18]. In fact, the large literature providing strong multi-method multi-level evidence that vaginal and clitoral orgasms are physiologically, psychologically, and clinically different is not presented to the readership by Laan et al. [1], leading to incorrect inferences and potentially damaging practice. Some of this important evidence (much of which was published in *JSM*) will now be noted: (i) sexual desire is greater for women who have specifically more frequent intercourse orgasm and specifically vaginal orgasm [3,19]; (ii) intimate relationship quality is better for women who have vaginal orgasm [3,9,20]; (iii) a history of vaginal orgasm is a protective factor against female sexual arousal disorder with distress, but masturbation is a risk factor for female sexual arousal disorder [11]; (iv) a history of vaginal orgasm is a protective factor against current manifest global orgasmic dysfunction [21]; (v) women with greater intercourse orgasm consistency (but not simply greater orgasm consistency from other orgasm triggers) have better concordance of vaginal and subjective responses to erotica [7,8]; (vi) women who have greater vaginal orgasm consistency have better attention to vaginal sensations during intercourse [4]; (vii) women with a history of vaginal orgasm manifest less functional muscular disturbance (of pelvic and vertebral rotation) of their spontaneous gait, regardless of history of clitoral orgasm [22]; (viii) clitoral masturbation during intercourse is associated with tremendous overestimates of the supposed lethal risks of intercourse [23]; (ix) frequency of intercourse orgasm (but not frequency of other orgasm sources) [24] and specifically having had a vaginal orgasm [2,3] are associated with greater sexual

satisfaction—these findings are consistent with multiple international studies finding that in multivariate analysis, it is frequency of penile–vaginal intercourse but not of other sexual activities that is positively associated with sexual satisfaction [24–27]; (x) anxious attachment (preoccupations about abandonment) is associated with lesser vaginal orgasm consistency, but with higher frequency of vibrator, anal sex, and clitoral masturbation orgasm [28]; (xi) greater alcohol consumption before sex is associated with less vaginal orgasm consistency, but is unrelated or positively correlated with frequency of other sexual behaviors [29]; (xii) women who have vaginal orgasm are more satisfied with their own mental health [2,3]; (xiii) women who were educated in their youth that the vagina (rather than only the clitoris) is a source of female orgasm are more likely to have vaginal orgasm in adulthood [4]; (xiv) greater (better) heart rate variability (a psychophysiological index of parasympathetic tone, associated with longevity and better emotion regulation) is associated with vaginal orgasm but not with other orgasm sources [30]; (xv) a greater lifetime likelihood of vaginal orgasm (but not of clitoral orgasm) is found in women with a more prominent tubercle of the upper lip (which might be related to some aspects of better fetal forebrain development) as compared with women with flatter or concave lip tubercle regions [31]; (xvi) relative to a control condition, the prolactin surge (relevant to central dopaminergic processes, and strongly related to the quality of the women’s orgasm and subsequent sexual satisfaction [32]) at orgasm was 400% greater for intercourse orgasm than for masturbation orgasm [33]; (xvii) women with a completely severed spinal cord (thus, no connection of the clitoris to the brain) can have orgasms from vaginocervical stimulation, verified by functional magnetic resonance imaging and by self-report [34–36]; (xviii) different peripheral nerves are involved in conducting sensation from the clitoris, vagina, and cervix to the brain [34–36]; (xix) in intact women, stimulation of the clitoris, vagina, and cervix activated different regions of the brain (as well as an overlapping region), indicating that different genital regions produce different brain responses [17], and providing clear evidence of physiological differences between vaginal and clitoral (and cervical) stimulation [37]; and (xx) in contrast to the authors dismissively mischaracterizing as an assertion (confusing empirical evidence with their own assertions) “Today, again authors claim that ‘clitoral’ orgasms are inferior to ‘vaginal’ orgasms” (p. 76), multiple empirical studies in various countries found that lack of specifically vaginal orgasm is associated with less adaptive defensive functioning, or in the technical language reflecting associations with poorer coping processes in both small children and adult psychopathological groups, greater use of “immature psychological defense mechanisms” [29,38,39]. Similarly, women with neurotic disorders were less likely to have intercourse orgasms than women without neurotic disorders, but they were no less likely to have orgasms from direct clitoral stimulation [40]. Interestingly, Laan et al. [1] report that lack of clarity of emotional states and ineffective emotion regulation strategies are risk factors for FOD. Those emotional impairments are expected consequences of immature defense mechanisms.

In section 8f, Laan et al. [1] provide grudging acknowledgment of the coital alignment technique (an intercourse-based treatment for orgasmic dysfunction), and mischaracterize it as simply increasing clitoral stimulation during intercourse (the approach relies heavily on coital synchronization [41]). Laan et al. [1] also report that the coital alignment technique was equally effective as directed masturbation, but the cited study actually showed that masturbation was inferior to the coital alignment technique in improving intercourse orgasm consistency [42]. The description of the coital alignment technique approach and results were reported more accurately in the recent *JSM* review of etiology and treatment of orgasm disorders in women [43] (another review article ignored by Laan et al. [1]). In an earlier paper co-authored by Laan, it was observed that “The lack of association between

intercourse and masturbation orgasm consistency has potential implications for sex therapy, because it may provide support for women bypassing directed masturbation in favor of more coitally focused interventions" [7] (p. 21). Other studies also showed that women's intercourse orgasm is inversely related to masturbation frequency [3,20], and that vaginal orgasm is associated with having one's first ever orgasm from intercourse rather than from masturbation (and vaginal orgasm is not correlated with orgasm from cunnilingus or partner masturbation) [3]. In promoting masturbation as the treatment for FOD, Laan et al. [1] make no mention of possible adverse effects of prescribing masturbation [44], including the association of masturbation (in multivariate analyses controlling for other sexual activities) with greater risk of female sexual arousal disorder [11], and with lesser sexual, relationship, and life satisfaction [25], among other adversities [27,45]. Of note, the aforementioned prolactin study provides experimental evidence of central physiological processes that might underlie some differences between masturbation and intercourse orgasm [33].

Thus, there is a large body of compelling evidence in the direction opposite Laan et al.'s assertions and recommendations. Not only are there many physiological, psychological, and interpersonal differences between vaginal and clitoral orgasm, but these differences are quite consistently in the direction of vaginal orgasm being associated with better physical and psychological health than clitoral orgasm. Although many of these differences likely precede adult sexual activity, some of these differences might be consequences of having vaginal orgasm. As noted in a recent *JSM* article [37], "However, one must also consider the possibility that specifically (vaginal orgasm) facilitates emotional growth and intimacy. If the latter is the case even in part, then failure to be supportive of specifically (vaginal orgasm) constitutes iatrogenic damage" (p. 963). Thus, one means by which the Laan et al. [1] guidelines risk harming women's health is preventing support for pursuing specifically vaginal orgasm (and the various health benefits associated with vaginal orgasm, some of which might be at least in part a result of vaginal orgasm). Another means by which the Laan et al. [1] guidelines risk harming women's health is simply not incorporating the best available evidence, which is required for evidence-based practice. It has been noted that many sexologists ignore and deny evidence contradicting the politically correct, clitorocentric theory of women's intercourse orgasm (which ignores both vaginal sensitivity and the differences between women who have vaginal orgasm and those who do not) [11,18,37,46,47]. Women's sexual, emotional, physiological, and relationship function should no longer be sacrificed on the altar of political correctness that has long guided practice in the field, and which is exemplified by Laan and colleagues' withholding and misrepresentation [46] of best evidence.

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[Correction added after online publication on 26 July 2013. The Editor's note has been added]

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The authors of the original manuscript cited in this letter to the editor were given an opportunity to respond in writing before publication and they respectfully declined.

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