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TREATMENT OF ORGASM DISORDER IN WOMEN WITH THE DIGITAL S-ON*app* METHOD

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Abstract

Objectives: **The present body of work presents a case study addressing the development of sexual behaviors in a patient with primary anorgasmia in order to reduce emotional distress manifested by guilt, embarrassment and performance anxiety, as well as learning new sexual patterns to increase pleasure and sexual satisfaction. Specifically, we sought to create a positive attitude toward sexuality as part of mental health and increase self-confidence in expressing one's sexuality. Reaching orgasm by the patient was not a stated goal, not to accentuate the distress, but the development of sexual behaviors aimed to increase the duration and intensity of arousal and more frequent manifestation of sexual desire, designed to create the conditions for its occurrence.**

Method: **This is a case study on a 44-year-old patient, during 20 sex therapy sessions of 1 hour each, for 22 weeks, May-September 2021. Assessment methods for Axis I and Axis II, anamnesis and clinical observation, structured, semi-structured and unstructured clinical interviews (Delcea C., 2021) and investigation of medical, family, sexual, socio-cultural, and psycho-social history (individual completion) - MCMI III psychometric tests (Millon), Scale of Anxiety Hamilton, HRSA (SEC), PDA Affective Distress Profile, Opris D., Macavei B. (SEC), YSQ-S3 Short Form Cognitive Questionnaire (SEC), DAS Dysfunctional Attitude Scale Beck A., Weissman A. (SEC); For sexual testing: Genogram of excitatory stimuli, (Delcea C., 2021), FSFI Female Sexual Function Index, Rosen M. 2000, FSDS Female Sexual Distress Scale, Derogatis, 2019, FOS Female Orgasm Scale, McIntyre, Smith, 2019, ORS The Orgasm Rating Scale, Mah K., Binik, 2019, MISSA Multiple Indicators of Subjective Sexual Arousal, Mosher DL, 2019- SISES Sexual Inhibition / Excitation Scale, (Milhausen RR 2019). Methods used in sex therapy intervention (face to face): to identify stimuli of pleasure, arousal and sexual relaxation, having as source the partner's body we used the Genogram of excitatory stimuli, the technique of anticipating excitatory stimuli and the technique of defocusing irrelevant stimuli. (Delcea C., 2021). Sensate focus and directed masturbation to identify individual arousal stimuli, and self-monitoring through journals. 3. Cognitive restructuring of dysfunctional cognitions. 4. Progressive desensitization, in the construction and practice of new exciting sexual behaviors. 6. Psychoeducation. 7. Relaxation techniques (eg breathing, mindfulness).**

Results: **Following the standard psychological assessment, the patient has no Axis I and II emotional disorders, and no history of sexual abuse. The MCMI profile shows a person without clinical personality disorders, but a very high level of Distress (PDA), present cognitive schemas, Negativism and Need for approval that outlines a possible anxious predisposition, as well as present dysfunctional attitudes of medium level, considered as predispositions for depression. Sexual testing with the score sc = 19 FSDS scale, (Derogatis, LR 2002) The sexual distress scale in women shows that the patient has**

a high level of stress that positively correlates with the existence of sexual dysfunction, manifested by feelings of shame, guilt , inadequacy, and average sexual satisfaction. From the 2 orgasm measurement scales, FOS (McIntyre - Smith, 2019) and ORS (Mah K., Binik, Y., 2019) there is a lack of experience of orgasm by the subject, throughout life and an increased dissatisfaction. The FSFI Scale Index of sexual functioning in women (Rosen R., 2000) shows the same difficulty in experiencing orgasm in the context in which sexual desire exists and the level of arousal is high, from the subjective assessment of the patient. Sexual desire - 4.2; Excitation - 5.1; Lubrication - 4.2; Orgasm - 1.2; Sexual satisfaction - 4.4; Disappearance - 0.9 (maximum = 6.0). The genogram of excitatory stimuli shows an insufficient register of excitatory stimuli on the partner's body, 4 out of 8 (face, chest and arms) and an absent register of excitatory physical stimuli having as source its own body, absent fantasies, unique, poor and repetitive scenarios.

Conclusions: **This is a patient without mental disorders with clinical significance, with predispositions for the installation of anxiety and depression, high level of distress. There is a poor sexual history and reduced and inadequate arousal. Absent fantasies, absent masturbation, dysfunctional cognitions about sex, "sex is unknown, forbidden, dangerous", register of excitatory stimuli on one's own absent body, and reduced for the partner's body, sexual pattern during predominantly passive sexual intercourse, on receiving pleasure, focused on the partner's body. There is a lack of development of arousal stimuli and consequently sexual behaviors maintain orgasm dysfunction.**

Key words: Orgasm, Sexual arousal, Primary anorgasmia, TOF, FOD, Orgasmic disorder in women, Arousal stimuli.

INTRODUCTION

Pleasure and orgasm are critical emotional states for adult sexuality, which is why it is necessary to maintain a healthy life style in general and sexual and romantic health as well. Sexual pleasure is an important part of every healthy sexual relationship. Orgasm is a unique, subjective experience of living fully, physically and psychologically with sexual pleasure and satisfaction even to an altered state of consciousness. It is closely associated with the joy of living life, happiness, love, sexual fulfillment, or the success of a relationship. It is a progressive accumulation of increasingly intense sensations of pleasure and arousal to a peak followed by the release of sexual tension and the feeling of physical and mental fulfillment, satisfaction and sexual relaxation. It is a part of our well-being and our physical and psychological health. It is not a luxury, but one of our rights to enjoy life and the meaning attributed to individual sexuality can be an extremely powerful motivator for energization and invigoration adapted to each age level.

Orgasm is seen as a reward for sexual activity and it has a great importance in continuing to initiate sexual experiences. Experiencing orgasmic sensations is a natural function of our body and psyche, which cannot be determined to appear voluntarily and cannot be stopped when it self-triggers. It is necessary to have certain conditions that we can control for the most part, namely the state of calm, relaxation in physical and emotional security (intimacy, self-image). Experiencing orgasm in women is more complex than in men, due to psychological and anatomical differences (a woman's body has more erogenous zones than a man's body). There are a number of psychological and psychosocial factors that affect orgasmic ability in both sexes. In the following, we will refer to orgasm as the stage of the human sexual response cycle in the approach to the case study we are referring to, namely the development of sexual behaviors in primary anorgasmia in women.

The prevalence of orgasmic dysfunction in TOF women (DSM V) is quite high, 42%, and some studies even show a 34% prevalence for primary anorgasmia (Lindau, 2007, Graham C., 2009). It is the second most common sexual dysfunction in women, after arousal and sexual desire disorder. Orgasm is a purely subjective feeling. The more important it is for a woman, the greater the distress she feels in the

case of primary and secondary anorgasmia or in the case of decreased orgasmic sensations.

The classic model of the human sexual response described by Masters and Johnson (1966), namely desire, arousal, orgasm and resolution, was an important starting point in describing sexual activity and treating the increasingly common sexual dysfunctions.

Based on this model, which is considered valid in both men and women, women's orgasm difficulties are seen as a persistent and recurrent inhibition of orgasm, manifested by delayed or absent orgasm after a normal phase of sexual arousal during sexual activity and staging of the orgasm cycle. sexual response.

This model is complemented by H. Kaplan with sexual desire preceding the arousal phase, and Brash-McGreer 1997 with the circular model of sexual response in women, showing that many women experience orgasm without progressively going through the phases described by the classical model. They can go directly from arousal to orgasm and satisfaction without sexual desire, or they can go through all phases without reaching orgasm. The circular pattern of sexual response in women is found in Figure 2. and refers to seduction, sensations, abandonment (orgasm) and reflexive (resolution).

Some authors consider the threshold of 15 minutes as the minimum duration of the arousal phase in orgasmic disorder in women and less than 15 minutes in the arousal phase in arousal disorder in women. Other authors, C. Delcea, 2021, suggest the threshold of 30 minutes of arousal without orgasm, in order to orient us towards a diagnosis of Orgasm Disorder in women.

And because the dysfunction of one phase of the sexual response cycle also leads to dysfunction of other phases, that is, an inhibition of orgasm may develop an inhibition of arousal, in our case study approach we considered a more detailed assessment of the stages of arousal by measuring stimuli, although the patient found her subjective level of arousal to be satisfactory. The duration of her arousal phase did not exceed 15 minutes in sexual activity with a partner.

We reviewed these additions to the classic model of the human sexual response because we considered them in our approach to case conceptualization and treatment plan.

This model shows that the sexual response cycle is oriented towards obtaining sexual pleasure, not for a specific purpose, and that any activity can lead to obtaining pleasure, without this aiming to orgasm.

In 2001, R. Basson (Fig. 3) stated that women can have many reasons to engage in sexual activity without having a sexual purpose. On the contrary, the purpose of sexual activity in women is not necessarily orgasm, but rather personal satisfaction which can manifest itself as physical satisfaction (it can be orgasm) and / or emotional satisfaction seen as intimacy in the relationship with the partner. Basson emphasizes in the sexual response in women, the importance of arousal stimuli, intimacy and finally satisfaction in the relationship with the partner. Metz believes that this current model is important for both the sexual satisfaction of women and mature couples.

We will continue to refer to sexual behaviors, according to CBT, the consequence of emotions associated with cognitions, thoughts, ideas about sex, sexuality and sexual intercourse.

Sexual behaviors are learned, from flirting, caressing, pampering, touching in non-sexual areas of the body to experiencing orgasmic sensations individually or in a sexual relationship. This learning involves exchanging ideas, with new, adaptive ones, through continuous practice and verification, until obtaining skills and attitudes about sexuality, which ultimately lead to the development of new sexual behaviors, the goal of this paper.

METHOD

The objective of the research

The development of sexual behaviors in a patient who has not experienced orgasm in her lifetime and their influence on the sexual distress felt by the patient.

The sexual behaviors we refer to in this study are the following:

Sensate focus on

- Identifying the pattern of excitatory stimuli having as source the person through self-exploration, self-observation of the whole body and specifically, the focus on the genitals, or directed masturbation.
- Identification of excitatory stimuli having as source the partner (when appropriate) or imaginative.
- Identification of sexual triggers, a repertoire of touches, caresses, hugs.
- Patterns of relaxation through mindfulness associated with imaginative sexual scenarios.
- Management skills, by inhibition and relaxation of the excitatory flow in sexual intercourse, in masturbation or sexual intercourse with a partner.
- Construction of sensual-sexual scenarios in writing, then repetition in imaginative,
- Mimicking a sexual act that includes orgasm.

Participants

Statystical data

The case study involved a 44-year-old patient, higher education, heterosexual orientation, currently not in a relationship.

Inclusion / exclusion criteria

Our patient met the eligibility criteria for our study, namely: to be over 18 years old and to have a sexual dysfunction such as the primary disorder, orgasm.

Description of the procedure

The patient requests the C.I.P. an evaluation of sex therapy for the reason for the absence of orgasm in sexual activity, from the beginning of sexual life and major distress related to this lack.

Ethical issues

The participant eligible for this case study has given his / her written consent to the purpose of the research and his / her participation in the testing as well as to the aspects of Regulation (EU) 2016/679 on the protection of individuals with regard to data processing. personal data and on the free movement of such data and repealing Directive 95/46 / EC (General Data Protection Regulation) and Law No. 506 (2004) on the processing of personal data and the protection of privacy, and on the research team that has the obligation to administer in safe conditions and only for the specified purposes the data it will provide: e-mail address (optional), socio-demographic data and subjective answers to the questionnaires.

Instrument

To identify the stimulus stimuli and sexual behaviors of the patient before the intervention, the following instruments were used:

1. The genogram of excitatory stimuli (Delcea C., 2019) is a tool for identifying excitatory stimuli located both on the partner's body and on his own body. These are 3 types of stimuli, described according to the phases of the human sexual cycle, starting with pleasure stimuli (what do you like, what will attract you?) That refer to sexual desire and interest, then arousal stimuli (what will excite you?), for the excitement and plateau phase and the Relaxation Stimuli (What relaxes you?) for the resolution phase. These stimuli are related, (by a subjective assessment, on a scale of 1 to 10, where 1 is minimum and 10 is maximum) to the sexual and non-sexual areas of the body, namely, for men, face, neck, chest, abdomen, arms, legs, penis, buttocks and back, and for women, face, neck, back, breasts, abdomen, vagina, arms, legs, buttocks.
2. Sexual triggers (Cass V., 2017) - questionnaire with individual administration
3. The 5 sexual cognitions (Metz M., 2018) questionnaire with individual administration
4. The 5 sensual and sexual dimensions of caresses / touches (Metz, M., Epstein, Mc Carthy, 2018) questionnaire with individual administration
5. Multiple indicators of subjective arousal (Mosher D., 1988,2019) questionnaire with individual administration
6. Inventory of Sexual Arousal and Inhibition (Women and Men), (Milhausen R.R., 2019) Individual Questionnaire
7. FSFI Index Function Sexual Female, Rosen M., 2000 individual administration questionnaire

8. FSFD Distress Female scale Function, Derogatis L., R., 2019 individual administration questionnaire
9. ORS Orgasmic Rating Scale, Mah K., Binik Y., 2019 individual administration questionnaire
10. OCS Orgasmic Consistency Scale, Mc Intyre - Smith a., Fisher W., 2019 questionnaire with individual administration

The following methods were used to identify new sexual stimuli and, implicitly, new sexual behaviors through sex therapy intervention:

- Sexual psychoeducation for understanding the anatomy and physiology of the genital tract and the human sexual response.
- Relaxation skills through breathing and minfulness exercises.
- Sensible focus on genital and non-genital self-exploration.
- S-ON*app*, Delcea C., 2021
- The technique of anticipating exciting stimuli. (Delcea C., 2019)
- The technique of defocusing on irrelevant stimuli. (Delcea C., 2019)
- Management of sexual anxiety (guilt, shame, failure) through cognitive restructuring and progressive desensitization.
- Management of disturbing factors. Disorder Management "- aimed at introducing into the new lifestyle 1 hour a day of meditation, relaxation, self-exploration, and permission to set healthy boundaries with those in the family of origin and in the relationship with the adolescent son, reducing the dependence on the relationship and conflict management skills. The patient partially gave up meeting the needs of others and began to give herself time and space for herself.
- Creating romantic fantasies.
- Creating a complete erotic scenario, completed with orgasm followed by the resolving phase.
- Pampering an orgasm
- Erotic flow control

Procedure

Sexual psychoeducation for understanding the anatomy and physiology of the genital tract and the human sexual response was achieved by presenting written texts and colored drawings, with associated explanatory tables.

Relaxation skills through breathing and minfulness exercises were initiated with the therapist, then the patient practiced them on homework. From Schultz Training, the focus on heat and weight sensations was preferred by the patient.

Through Sensate focus on genital and non-genital self-exploration, the patient identified her own erogenous zones, by observation and touch with varying degrees of pressure, the focus being divided on skin temperature, (hot-cold) especially on heat sensations, and on the texture (smoother, or rougher skin).

Through self-monitoring in diaries, the patient kept track of the evolution of this process of self-exploration, being more motivated to continue.

Genogram of excitatory stimuli and S-ON-*app*, Delcea C., 2021

On a scale of 1 to 10, the patient chose one of the most satisfying sexual experiences and noted the degree to which the partner's body parts pleased (attracted) and sexually aroused her.

st. pleasure = 50/8 = 6.25 st excitement = 38/8 = 4.75 relaxation = 55/8 = 6.87

The *Genogram of excitation stimuli* **of the partner`s body (Delcea, 2019)**

	Pleasure	Excitation	Relaxation
FACE	10	6	9
NECK	2	2	9
BACK	6	3	9
ABDOMEN	9	6	9
ARMS	9	5	8
FOOT	4	4	8
PENIS	0	4	0
CHEST	10	8	3

The individual Genogram of excitation stimuli on one`s own body (Delcea, 2019)

	Pleasure	Excitation	Relaxation
GIRL (EYES, SMILE)	10	10	8
NECK	6	2	8
BACK	2	6	9
ABDOMEN	8	6	9
ARMS	9	7	8
FOOT	7	0	8
vaginas	0	0	0
breasts	2	0	3

For the development of the patient's sexual behaviors, we suggested a detailed description of the excitatory actions, taking into account all the pleasant information coming through the sense organs. (What do I do? How do I do it? How long? What do I do right after? What do I do at the same time?) Thus, the patient became aware of sexual triggers and the pleasant way of being toucheds or those that only relax her. It was important to distinguish a very excitatory touch from from a pleasant one and from another that offers her only relaxation. This differentiation made it possible to create the complete erotic scenario described verbally, in writing, followed by the imaginary experience of sexual intercourse by controlling the flow of arousal and inhibition.

The technique of anticipating arousal stimuli (Delcea C., 2019) aimed at orienting the patient towards combining the stimulation of their own erogenous zones with fantasies that would maintain sexual arousal as much as possible to more intense levels of sensations.

Defocusing technique on irrelevant stimuli. (Delcea C., 2019) contributed to the description of the erotic scenario by diversifying the exciting stimuli. The management of sexual anxiety (guilt, shame, failure) has been done through Cognitive Restructuring and Progressive Desensitization. Cognitive restructuring of dysfunctional ideas that "sex is unknown, therefore it is dangerous" was achieved through Socratic dialogue, role play and replaced with adaptive cognitions such as "sex is healthy", "sexual pleasure is a state of physical and mental well-being" argued through the physiology texts of sexual intercourse and the benefits in sexual and relational satisfaction obtained from sex.

Through progressive desensitization we associated the state of relaxation maintained by the technique of focus on breathing with the development of the erotic scenario in sexual intercourse, progressive, in stages, lasting 1-2 minutes maximum or more depending on how much the patient could support. I successively followed the start with an excitatory behavior 1 min old, then the introduction of another new one, 1 min, at the same time maintaining the relaxation by breathing, then again, another excitatory sexual behavior old, as long as the patient could support. To reinforce the new exciting behavior, the technique always ends with the new fantasy (or new sexual behavior). I also used the association with Corrective Self-Suggestions. "I can handle intense and pleasant emotions. I allow myself to feel sexual pleasure. " Another change was the introduction of masturbation, absent in the patient until then. I avoided the word "masturbation" at the beginning of the intervention, using self-exploration, self-discovery of areas and my own arousal stimuli. The most pleasant touches in certain areas of the body, recently discovered associated with detailed descriptions of aromas, sounds, tastes have been declared as new sexual behaviors and strengthened at home by re-exploration and repetition. The creation of romantic fantasies through library therapy, romantic movies, choice and knowledge of sex toys has significantly increased sexual fantasies and arousal sensations in the genitals, especially the clitoris of the patient.

1. Creating a complete erotic scenario, completed with orgasm followed by the resolving phase.
2. Mimicking a sexual act ending in orgasm.

Erotic flow control by managing the 3 types of touches, excitatory, pleasurable and relaxing that balance arousal with sexual inhibition.

RESULT

From the point of view of the sexual response cycle, the patient is blocked in the plateau phase of the sexual cycle, in the refractory period, when the arousal no longer increases above a certain limit, even decreases slightly and then increases again after the arousal resumes shortly. until it reaches orgasm only if stimulus stimuli are sufficient. She had an avoidant pattern for intense sensations such as orgasms.

The reduction of the patient's sexual distress began with the understanding of the level of arousal in the plateau phase of psychoeducation texts, namely that arousal in this phase does not decrease but remains at the same level for a few minutes depending on the degree of relapse of the subject. It is a "breath", after which, through exciting touches, both women and men can consciously increase through new sexual stimuli, the level of arousal to the level of orgasmic ones. She understood that this point where she was stuck was physiological and not her personal deficiency. She continues to learn relaxation techniques, which become a routine 1 hour a day, identifies sexual triggers, intense arousal stimuli, in the classic erogenous zones, genitals, but also in non-genital areas such as the umbilical region, face and popliteal .

She starts watching sex education movies, buys some sex toys and is not at all concerned about orgasm, but only about the experience itself. The patient reaches orgasm in the 10th week of sex therapy, by masturbation, without this being a stated goal. The duration of sexual scenarios, fantasies and self-stimulation, have greatly diversified arousal stimuli, increasing the duration of arousal from 15 minutes to 25-30 minutes. The level of sexual anxiety has dropped significantly, as she becomes motivated and willing to repeat the experience more often. She does not reach orgasm every time, but she is very happy with herself and focused on maintaining and increasing the intensity of the sensations of pleasure and arousal through her own sexual patterns. On average, she experiences orgasm of different intensities 5 times until the end of the therapy, the main objective being relaxation, pleasure and satisfaction with the new discoveries of her body.

DISCUSSIONS

The most important changes in the patient's attitude, in chronological order, began with the re-relaxation after understanding the plateau phase, which eliminated the feeling of guilt, helplessness and failure, and then became more and more confident by learning to relax. The next important moment was the discovery of one's own erogenous zones and excitatory stimuli through the genogram and then through sensible focus, followed by the moment of associating relaxation with newly discovered behaviors. The last important moment in the therapy was the fine discrimination between an exciting touch, a relaxing one and a pleasant one, which, after repeated reinforcements, outlines an erotic scenario of a complete sexual act.

After identifying the stimuli of pleasure, arousal and sexual relaxation of the patient, of her arousal triggers, of practicing some types of touches (caresses) destined to increase the levels of sexual arousal, simultaneously with the acquisition of relaxation patterns, the patient is able and eager to practice. both scenarios of sexual behaviors through masturbation, and in penetrating acts with an imaginary partner. In our case, the patient never experienced orgasm, from the beginning of life, neither by masturbation, nor by other stimuli in the penetrative act, although the arousal was present, but as it was discovered during sexual testing, the level of her arousal was not enough. , neither as time nor as intensity. We considered that the subject meets the DSM 5 criteria for Primary Anorgasmia, severe as Primary Diagnosis and Secondary Diagnosis Desire / arousal disorder.

To differentiate between adaptive and maladaptive sexual behaviors, we considered classifying the Mosher DL (1980) model with 3 patterns of arousal: 1. Pattern of interaction with the partner focusing on his body and sexual interaction, 2. Pattern of interaction with himself with a focus on one's own emotions and sensations (guided imagery) and 3. With a focus on external stimuli (video, sex toys, role-playing games, erotic fantasies). Our patient used only one pattern of arousal, the one focused on the interaction with the partner and on his body, totally missing the others. I asked the patient to imagine that she is starting a sexual act, through sensual, erotic thoughts, about her partner, fantasies, with her eyes closed, and to tell what happens when she gets aroused, with as many details as possible. We guided the patient to use all 3 patterns as well as the technique of anticipatory stimuli (Delcea C., 2021) which emphasizes the need to mentally prepare the sexual response cycle to accommodate it without inferring maladaptive emotions of shame, guilt, frustration in our subject. WHAT DO I THINK NOW? WHAT DO I DO? WHY? WHAT DO I DO IMMEDIATELY AFTER? In cognitive restructuring we used Socratic dialogues, role play, progressive desensitization, proprioceptive exposure.

In the progressive desensitization I suggested the association of the relaxation pattern already learned with the imagination of a sensual and erotic scenario of initiating a sexual, imaginative act, What do I do? WHAT I FEEL ? WHAT DO I HEAR? WHAT DO I WANT TO HEAR? WHAT DO I DO IMMEDIATELY AFTER? WHAT DO I THINK NOW? WHAT DO I DO AT THE SAME TIME WITH… ..? 3 consecutive sessions to strengthen the new sexual pattern of positivity and acceptance of the concept of having sex or making love.

Approaching low tolerance to intense orgasm-like emotions

We found here that the patient has a low tolerance for intense emotions such as intense arousal, similar to the climax, this being an additional reason in her blockage to allow the orgasm to occur. This fear of losing control is often invoked in the etiology of female anorgasmia. In the moment before orgasm, I focused on breathing exercises, Jacobson muscle relaxation until calm and then continue the imaginative exercise.

I gave homework, journaling negative thoughts and emotions associated with specific sexual situations.

I recommended focusing exercises on the sensations of pleasure felt individually. Because their goal is not the pleasure of the partner, but the pleasure of the woman touching the partner, I constantly encouraged the self-discovery of new exciting stimuli of one's own body and the development of sexual fantasies, in parallel with the focus on the partner and sexual interaction.

Note: We mention that, although the patient was not in a relationship at the time of therapy, we suggested that she consider the experiences of the last relationship, which she considered to be the most sexually active.

The length of time the patient maintained the pre-orgasmic and orgasmic sensations gradually increased over the 18 weeks, from 3 min, then 10 min, then 20 min, then 15 min, to 25 min.

The patient attributes to the orgasmic experience a new sense of development and self-knowledge, of increasing sexual self-esteem and finally, for a life lived with more joy.

Recurrence prevention

We agreed with the patient that the presence of any 2 of the events below, determines the refocusing by individual effort on the daily practices of relaxation and self-arousal or by addressing in Sex Therapy: 3 consecutive days of lack of relaxation and self-training. arousal (if single), 2 days of unresolved conflicts in the family of origin, 1 day of unresolved conflicts in the mother-son relationship, 1 week without socializing and the tendency not to leave the house for 1 week, loss of interest in once pleasant things, Melancholy, sadness, a few days 2-3 days, 2 days of insomnia and mental and physical fatigue 2 days in a row.

Homework was aimed at acquiring sexual skills: a list of pleasurable things or activities,

a list of things or activities that relax her, self-arousal practice, (masturbation), (genital appreciation), relaxation techniques and diversification of sexual repertoire, (description detailed hand-touching, detailed description of touching one's face, appreciation of one's naked body in intimacy, and in the mirror, drawing the body with erogenous zones, neutral areas of the body and unpleasant areas of the body, fantasies, new exciting stimuli), identification of other possible problems related to body image, types of sexual preference attachment, patterns of verbal and nonverbal communication in the couple, patterns of relationships in the couple.

CONCLUSIONS

We reapplied the Female Sexual Function Index FSFI - Rosen M, 2000 where Scores for reaching orgasm by clitoral stimulation have significantly positive notes. The Derogatis scale of sexual distress FSFD-SC = 10, compared to 19 before Sex Therapy shows the lack of Distress level. Psychoeducation sessions positively impacted the patient's image of sex and sexuality, viewed both in terms of physical and mental health and by offering implicit permission to feel pleasure and to express the patient's sexual self. The therapy consisted of 22 sessions over 5 months. Session 1,2,3 (1 h): clinical evaluation, announcement of results, establishment of treatment plan and recommendations. Session 4,5,6,7,8 (1 h) Psychoeducation. Session 9,10,11,12,13,14,15, 16, so 8 actual intervention sessions lasted 30 min = cognitive restructuring and relaxation techniques, and 30 min identification of exciting stimuli, creation of sexual scenarios, fantasies and creation of new patterns of sexual behavior. In the 10th session the preorgasmic sensations become more and more intense and the patient experiences orgasm by clitoral stimulation, although she had not masturbated until then. She gradually learned this self-exploration and self-touch. The description of her orgasm is the short but intense sensation of disintegration and floating, very pleasant, of a relaxation and satisfaction unknown until then.

The patient continues masturbation and relaxation and pleasure exercises 5 times a week, more often than before, she does not always have an orgasm but, out of 6 attempts, 4 experiences are orgasmic. At the same time, follow the exercise program. The goal was not orgasm but the quality and diversity of her physical and subjective sensations. Session 16 - 22 - 1h - redefining arousal patterns, prevention of recurrence, post-therapy evaluation and other recommendations. The literature considers that An orgasms are difficult to treat, but they are treated. Our case confirms this and its specificity shows that sexual psychoeducation combined with cognitive behavioral techniques of sex therapy, focusing on sensations and diversifying the register of excitatory stimuli, open the way to accepting the unknown in this journey of sexual self-knowledge and self-expression. "Pleasure is a statement of life. Pleasure is an addiction to life rather than a goal for social functioning. Virginia Johnson speaks of the significance of sexual pleasure as "a genuine satisfaction that makes us feel complete human beings." Pleasure brings meaning to our lives. The 44-year-old patient with primary anorgasmia, with anxious-avoidant attachment, histrionic personality traits and predispositions to anxiety and hyperactive behavior, participates in 20 sex therapy sessions for self-knowledge training and work on her sexual identity, with the purpose of experiencing her sexuality more pleasantly. In other words, to improve her expression as a sexual being and the quality of her sex life. (Delcea C., 2020, Delcea C., 2019). The acquired sexual behaviors during therapy were as follows: masturbation completed with orgasm; map of one's own excitatory stimuli; behaviors of physical and mental relaxation through mindfulness; education of cognitive impairments (analysis of the reasons for anxiety); excitation activation / growth behaviors; excitatory erotic flow management; increased self-esteem related to sexual stimuli; increase sexual satisfaction.

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