Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education

Volume 1 | Issue 2 Article 4

2019

Clinical Implications in Vaginal Orgasm Response

Lindsey M. Brown McCormick
University of the Cumberlands

Sherry Todd
University of the Cumberlands

Laura Schmuldt
University of the Cumberlands

Kathryn Russ
University of the Cumberlands

Cristen Wathen
Palo Alto University

Recommended Citation

Brown McCormick, L. M., Todd, S., Schmuldt, L., Russ, K., & Wathen, C. (2019). Clinical Implications in Vaginal Orgasm Response. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education, 1* (2). https://doi.org/10.34296/01021011

Clinical Implications in Vaginal Orgasm Response

Lindsey M. Brown McCormick
University of the Cumberlands

Sherry Todd
University of the Cumberlands

Laura Schmuldt
University of the Cumberlands

Kathryn Russ
University of the Cumberlands

Cristen Wathen
Palo Alto University

Previous research has shown that counselors feel uncomfortable addressing clients' sexual concerns due to a lack of education on topics related to human sexuality. Various studies have attempted to identify the characteristics of vaginal orgasm, including whether women and other people with vaginas (PWV) can achieve different kinds of orgasms. The current study examines responses to participants surveyed across the United States on their orgasm response and compares responses of participants who achieved orgasm through masturbation and those who achieved orgasm through sex with a partner to determine whether PWV experience one kind of orgasm during masturbation and experience a different kind of orgasm during sex with a partner. Results from the current study suggest that there are two distinct orgasm experiences achieved by PWV which differ in physiological and psychological response. Counselors and counselor educators can use results from this study to help expand their knowledge on sexual response to feel more confident in their practice.

Keywords: vaginal orgasm, masturbation, partnered sex, people with vaginas

Introduction

Human sexuality is a significant aspect of human development and experience (Jahoda & Pownall, 2013). Because of this, it is plausible to believe that mental health counselors may encounter a client seeking treatment for a sexual issue. A woman who may not be formally educated on topics related to her sexuality could face embarrassment when asked by a counselor if she has ever achieved sensations associated with orgasm in the past. Previous literature has shown that mental health clinicians from various disciplines, including counselors, do not always feel comfortable assessing sexuality-related topics with clients (James, 2007; Kazukauskas & Lam, 2009; Bloom, Gutierrez, & Lambie, 2015; Lenes, Swank, & Nash, 2015). Counselors have reported that they do not feel like they have received adequate training on topics related to human sexuality to feel confident enough in addressing these concerns with their clients (Bloom et al., 2015). As of 2016, only the state of Florida requires coursework in human sexuality in order to obtain independent licensure as a professional counselor (American Counseling Association, 2016).

There are several reasons why individuals may seek counseling for sexuality-related issues. Sexual dysfunction, such as dyspareunia or anorgasmia, related to depression could be one of those factors. Increased depression has been shown to correlate with increased sexual dysfunction (Fabre & Smith, 2013). Previous literature has identified the effects of depression and selective serotonin reuptake inhibitors (SSRIs) on sexual function as well (Fabre & Smith, 2013). Researchers have even suggested that sexual dysfunction is just as important as other diagnostic criteria for depression, and that sexual dysfunction should be measured in depressed individuals before beginning medication treatment for depression (Fabre & Smith, 2013).

Though many agree that sexuality education should receive more recognition, there is a considerable amount of vagueness regarding human sexuality for counselors-in-training and licensure as a licensed professional counselor (LPC, Diambra, Pollard, Gamble, & Banks, 2016). Dup-

Corresponding Author

Lindsey M. Brown McCormick
University of the Cumberlands
6178 College Station Drive
Williamsburg, KY 40769
E: lindseybrown.lpc@gmail.com
P: (859)429-0449

koski's (2012) analysis of the American Counseling Association (ACA) and Association for Counselor Education (ACES) Syllabus Clearinghouse revealed that only 57 out of 395 syllabi included the word 'sex,' and only four courses had sexuality as their focus. The National Board for Certified Counselors (NBCC) has not required a course in human sexuality for National Certified Counselor certification in the past (NBCC, 2012). However, counselor educators have advocated for more specific information related to human sexuality to be introduced into counselor education programs, integrating ideas from the American Association of Sexuality Educators, Counselors, and Therapists (AASECT; Zeglin, Dam, & Hergenrather, 2017). Zeglin et al. (2017) proposed ten competency domains to aid counselors in working more effectively with clients: Ethical/Professional Behavior, History and Systems, Anatomy/Physiology, Sexual Identity, Sexual Development, Intimacy and Interpersonal Relationships, Pleasure and Sexual Lifestyles, Sexual Functioning, Health/Medical Factors, and Sexual Exploitation.

Orgasm response is one concern for which a person might seek counseling. Kinsey, Pomeroy, Martin, and Gebhard (1953) attempted to define orgasm in broad terms, defining it as a sudden reduction of sexual tension. During orgasm, there is a peak in heart rate, blood pressure, and in respiration (Masters & Johnson, 1966). Often during orgasm, the extreme pleasure causes a characteristic 'orgasm face' as well (Masters & Johnson, 1966; Levin, 2014). Most studies have focused on the genital physiologic changes that occur during orgasm, mainly studying the muscle contractions that occur (Mah & Binik, 2001; Dubray, Gérard, Beaulieu-Prévost, & Courtois, 2017). Researchers have tried to broaden the definition of orgasm by including the psychological effects that are associated with orgasm (Mah & Binik, 2001; Dubray et al., 2017).

Previous literature suggested that all vaginal orgasms are basically the same (King, Belsky, Mah, & Binik, 2010). However, the idea that there are variations between vaginal orgasms and clitoral orgasms has been under-researched, but has been a popular opinion (Wimpissinger, Springer, & Stackl, 2013). King and Belsky (2012) reported this as the 'Masters and Johnson model' of female orgasm: one type of orgasm, no matter how it is brought on or by whom. Contrary to this, previous research has shown that women report that their orgasms differ in intensity, location, and phenomenology, as well as emotional components (Hite, 1976). Several previous researchers have reported that especially in the female, stimulation of different sites creates different orgasmic feelings (Levin, 2004). This has been found to be especially true with the clitoris (described as sharp, intense, 'electrical' feelings) in comparison to the anterior wall of the vagina (described as throbbing, deep feelings; Levin, 2004).

King and Belsky (2012) reported that women frequently reported experiencing more than one kind of orgasm. Participants in their study reported two different kinds of orgasm. One orgasm was experienced "deep inside," and the other was experienced "on the surface" (p. 1154). Characteristics of deeper orgasms were experiences such as shuddering of the entire body and feelings of intense pleasure, loss of self, and loss of thought. King and Belsky (2012) reported that deeper orgasms were significantly more likely to occur through sex where there was penetration involving a partner.

The current study is similar to the study conducted by King, Belsky, Mah, and Binik (2010), where it was concluded that women can achieve up to four differing types of orgasm. Unlike the 2011 study, however, this study helps to provide insight on the physiological sensations achieved during orgasm by utilizing the Bodily Sensations of Orgasm (BSO) questionnaire first published in 2017 (Dubray et al., 2017).

We hypothesize that participants will report experiencing more than one kind orgasm as previous literature has shown. We hypothesize that these different experiences will be identified in participants who report experiencing orgasm through masturbation versus participants who report experiencing orgasm through sex with a partner. Participants were divided into these groups based upon previous studies examining biopsychosocial models of orgasm experience that speculate orgasm is comprised of both physical and psychological/interpersonal experiences (Davidson, 1980; Warner, 1981; Newcomb & Bentler, 1983; Mah & Binik, 2002). This was also the design of King et al.'s (2010) study, as well as Dubray et al.'s (2017) study confirming the validity of the BSO questionnaire. The current study will help determine whether women and other people with vaginas (PWV) report experiencing different vaginal orgasm experiences during masturbation and sex with a partner. We hypothesize that these orgasm experiences will vary between both physiological and psychological responses.

Methods

Participants

The participants for this study included 369 cisgender women and gender non-conforming individuals with vaginas. For the purpose of this study, cisgender women were participants whose gender identity matches the sex they were assigned at birth, and gender non-conforming individuals with vaginas were participants who do not indentify as a gender other than their biological sex and were born with a vulva and vagina. This study was a doctoral dissertation that obtained Institutional Review Board approval through University of the Cumberlands. Individuals were recruited to participate by social media or email invitation. All information gathered for this study was anonymous and completely voluntary. Participants confirmed that they had either experienced orgasm through solitary masturbation (n = 204) or

during sex with a partner (n = 165).

Participants' age ranges varied greatly between 18 and 65 and over, with the most reported age range being 25-34 (n = 193). Education levels varied greatly between participants as well, with the most reported education level being 'graduate degree' (n = 179). A significant number of participants identified as 'white' (n = 313), cisgender (n = 353), heterosexual (n = 269), Christian (n = 152), married (n = 162), and 'very satisfied' in their relationship (n = 168). Participants' location throughout the United States varied greatly, the most reported region of the United States being 'East South Central,' which included Alabama, Kentucky, Mississippi, and Tennessee (n = 102).

Materials

Bodily Sensations of Orgasm questionnaire. The Bodily Sensations of Orgasm questionnaire (BSO) is a 22-item self-report questionnaire describing various sensations and reactions associated with achieving orgasm (Dubray et al., 2017). Utilizing previous literature and research, a list of sensations was compiled of 45 items initially. These items were sorted into four categories according to physiological response and Courtois et al.'s (2014) neurophysiological model of orgasm: cardiovascular sensations, autonomic sensations, muscular sensations, and negative sensations such as headaches (Dubray et al., 2017). Participants were asked to rate each item based on the extent to which they experienced each sensation using a 5-point Likert scale where '1' means "not at all" and '5' means "extremely". After testing for construct validity, wording for some items was changed, and the number of items was reduced to 28 (Dubray et al., 2017)(Dubray et al., 2017).

Orgasm Rating Scale. The Orgasm Rating Scale (ORS) is a 40-item self-report adjective rating scale. The ORS consists of two subscales measuring sensory and cognitive-affective dimensions of orgasm, based upon a two-dimensional model of the psychological experience of orgasm that has been previously investigated (Mah & Binik, 2001). The sensory dimension of the scale represents the perception of physiological events that occur (e.g., pelvic contractions), where the cognitive-affective dimension of the scale represents the subjective evaluations (e.g. intensity) and emotions (e.g. love, intimacy) that are associated with orgasm (Fisher, Davis, & Yarber, 2010). Participants were asked to rate each adjective on a 0-5 Likert scale according to how well each adjective describes their most recent orgasm experience where '1' means "not at all" and '5' means "extremely" (Fisher et al., 2010) . The ORS was developed to describe orgasms experienced by both masturbation and sex with a partner.

Procedure

As previously mentioned, participants were recruited through social media platforms and email invitations. Participants who chose to participate were asked to follow the link to SurveyMonkey.com to complete the materials. Participants were prompted to read the informed consent, agree that they were born with a vagina, confirm that they had achieved orgasm through solitary masturbation and sex with a partner in their lifetime, and agree that they were 18 years of age or older. Participants were then asked to complete the BSO questionnaire on a 5-point Likert scale, followed by the ORS on a 5-point Likert scale. Lastly, participants were asked demographic questions about themselves and debriefed regarding the nature of the study.

Results

A one-way analysis of variance (ANOVA) was conducted to compare the means between the 'solitary masturbation' and 'sex with a partner' sample groups. Data analysis showed statistical significance for some of the variables. For physiological sensations, there was a significant difference found for 'perspiration' between the solitary masturbation and sex with a partner group, $F(6, 362) = 3.465$, $p = .002$, $\eta^2 = 0.05$. There was a statistical significance found for 'choppy/shallow breathing (apnea)' between the two groups, $F(6, 362) = 3.436$, $p = .003$, $\eta^2 = 0.05$. There was a statistical significance found for 'shivers/goosebumps' between groups, $F(6, 362) = 2.842$, $p = .011$, $\eta^2 = 0.04$. There was a statistical significance found for 'hypersensitive clitoris' found between the two independent groups, $F(6, 362) = 3.210$, $p = .004$, $\eta^2 = 0.05$. There was significant difference found between groups for 'flowing,' $F(6, 362) = 2.137$, $p = .049$, $\eta^2 = 0.03$. There was also a significant difference found between the two independent groups for 'vulvular pulsations,' $F(6, 362) = 2.405$, $p = .048$, $\eta^2 = 0.03$. For psychological sensations, there was a significant difference found for 'trembling' between independent groups, $F(6, 362) = 2.647$, $p = .016$, $\eta^2 = 0.04$. as well as 'spurting,' $F(6, 362)$, $p = .005$, $\eta^2 = 0.05$. Tables 1 and 2 display the results of the analysis along with group means and SD.

Discussion

As discussed previously, scholars have attempted to research the possibility that women have more than one kind of orgasm. However, the question has never been definitively answered. While Masters and Johnson (1966) concluded that women could only achieve one type of orgasm, more current scholars have proposed the possibility of as many as four different types of orgasms women can achieve (King et al., 2010). The analysis for this study showed a significant difference between the orgasms reported during partnered sex and orgasms reported during solo sex (i.e,. masturbation) on the

Table 1
Group Means and Standard Deviations for Bodily Sensations of Orgasm Questionnaire

Scale	*M*	*SD*
Increased heartbeat	3.38/3.61	0.93/0.90
Heart beating stronger	3.30/3.52	1.01/0.94
Faster breathing	3.33/3.88	0.98/0.88
Overall muscular tension	3.94/4.04	0.91/0.87
Choppy/shallow breathing	2.65/2.96	1.28/1.26
Increased blood pressure	2.62/2.68	1.09/1.02
Moaning	2.53/3.7	1.23/1.08
Hardening nipples	3.02/3.35	1.23/1.17
Vulvular pulsations	3.89/4.01	1.09/1.04
Shivers/Goosebumps	2.53/2.69	1.37/1.33
Anal contraction	1.94/1.97	1.06/1.07
Hypersensitive clitoris	4.04/4.09	1.09/1.10
Clitoral pulsation	3.68/3.56	1.21/1.26
Lower limbs spasm	2.71/2.48	1.36/1.30
Abdominal contractions	2.692.48	1.26/1.24
Cranial pulsations/Headaches	1.35/1.43	0.81/0.92
Facial tingling	1.25/1.37	0.65/0.85
Reddening of the skin/Rash	1.57/1.64	1.03/0.99
Perspiration	1.95/2.44	0.97/1.02
Hot flashes	1.58/1.67	0.90/1.01

Note. Values are written 'masturbation group scores/sex with partner group scores.'

Table 2
Group Means and Standard Deviations for Orgasm Rating Scale

Scale	*M*	*SD*
Building	3.17/3.49	1.30/1.29
Swelling	2.30/2.33	1.18/1.28
Flowing	2.12/2.48	1.23/1.32
Close	1.92/3.27	1.20/1.42
Pleasurable	4.37/4.56	0.79/0.70
Soothing	3.06/2.84	1.29/1.39
Quivering	2.84/3.01	1.24/1.29
Passionate	2.45/3.99	1.36/1.00
Relaxing	3.57/3.33	1.21/1.29
Flooding	2.23/2.54	1.36/1.39
Elated	2.93/3.52	1.23/1.32
Throbbing	3.18/3.22	1.27/1.30
Rapturous	2.11/2.47	1.29/1.42
Spreading	2.24/2.24	1.33/1.30
Flushing	2.25/2.48	1.25/1.25
Fulfilling	3.71/4.25	1.14/0.92
Shooting	1.68/1.88	1.10/1.28
Euphoric	3.17/3.75	1.29/1.15
Unifying	1.94/3.41	1.25/1.35
Peaceful	2.62/2.73	1.29/1.26
Tender	2.14/2.84	1.24/1.25
Shuddering	2.67/2.73	1.31/1.34
Loving	2.17/3.93	1.26/1.09
Trembling	2.67/2.95	1.25/1.26
Satisfying	4.05/4.46	0.91/0.73
Ecstatic	2.78/3.42	1.34/1.27
Spurting	1.58/1.75	1.02/1.14
Pulsating	3.36/3.42	1.22/1.22

Note. Values are written 'masturbation group scores/sex with partner group scores.'

following variables: perspiration, choppy/shallow breathing (apnea), shivers/goosebumps, hypersensitive clitoris, vulvular pulsations, flowing, trembling, and spurting.

Based upon the analysis, there is some evidence to argue that PWV have at least two different experiences of orgasm: one experienced by solitary masturbation and a different one experienced by sex with a partner. This is consistent with Mah and Binik's (2002) results, as well as King et al.'s (2010) results. The use of the BSO questionnaire helped to provide further distinction in the different kinds of orgasms, which has yet to be done in a study of this type or this magnitude in the United States. This data is also consistent with King and Belsky's (2012) previous results, where women reported experiencing two different kinds of orgasms.

There are several limitations of this study that should be acknowledged. The first limitation is the lack of laboratory evidence in the current study. In previous studies of this kind, several of the participants have volunteered to undergo clinical tests such as fMRIs and observation by the researchers or laboratory assistants. However, this study was conducted via anonymous self-report, with little ability to control for variables that could be observed in a lab setting. A study like this would allow medical and mental health professionals to examine any differences in variables such as brain function in women during solitary masturbation and sex with a partner. An additional benefit of laboratory research would be monitoring participants' completion of the BSO within thirty minutes of experiencing orgasm. Self-report data collection, used in this study, does not allow for the researcher to know if that took place, while data collection in other settings, such as a sexuality research laboratory, could do so .

A recommendation for future research would be conducting qualitative interviews with participants. This would allow participants to define their own orgasm experience, as well as allow participants to define what terms like 'woman' and 'gender non-conforming individual' mean to them. Furthermore, future research could examine the variations in response of the ORS and BSO between participants who identify as being born with a vulva and vagina, and participants who have undergone gender confirmation surgery to have a vulva and vagina. Researchers could also examine responses of individuals who self-identify as 'intersex,' meaning they have both male and female sex organs. Another recommendation would be more widespread participant data collection

in both the United States and other countries. Future research could expand to allow for comparison between participants from all locations. This could allow for a cross-cultural comparison of vaginal orgasm response, as well as cross-cultural definitions of terms like 'woman' and 'gender non-conforming individual.'

One recommendation for future practice is for counselor educators to use the results of this study in their classrooms. Specifically, counselor educators teaching courses on human sexuality can use the results of this study to help educate counseling students on the experience of the vaginal orgasm, as well as on how vaginal orgasms differ from one another, and how vaginal orgasms differ from penile orgasms. A recommendation for clinicians is to utilize data from this study to further expand their own knowledge on the subject of orgasm. Clinicians who feel that they are lacking in knowledge and comfortability in regard to vaginal orgasm can use this information as a learning tool to feel more confident in addressing clients' concerns related to vaginal orgasm response.

Another recommendation for future practice is for counselor education programs to expand their curriculums to include human sexuality courses. Previous research has shown that clinicians struggle to discuss human sexuality with their clients for various reasons (Kazukauskas & Lam, 2009). There is a lack of education on the topic of human sexuality within several counselor education programs (Dupkoski, 2012). Scholars have suggested that education on clinical sexuality and a clinician's comfort with the topic of human sexuality allow for clinicians to discuss these topics with their clients (Juergens, Smedema, & Berven, 2009). Currently, Florida is the only state that requires individuals seeking licensure as a professional counselor to have completed coursework in human sexuality (ACA, 2016). While completing a course in human sexuality is not a requirement for licensure as a Licensed Professional Counselor in all states, allowing for students to take a course on human sexuality will help counselors in training to feel more comfortable and knowledgeable about these topics in their clinical practice.

References

American Counseling Association. (2016). *Licensure requirements for professional counselors: A state-by-state report*. American Counseling Association. Retrieved from http://web.oru.edu/current_students/class_pages/grtheo/mmankins/CounselingLicensure/ORU%20Counseling%20Licensure%20Requirements%20Website%20Update%202-16-16/state%20licensure%20requirements%202016%20edition.pdf

Bloom, Z. D., Gutierrez, D., & Lambie, G. W. (2015). Sexual opinion survey: An exploratory factor analysis with helping professionals. *American Journal of Sexuality Education*, *10*(3), 242–260. doi:10.1080/15546128.2015.1049315

Courtois, F., & Dubray, S. (2014). The neurophysiology of orgasm. *Current Sexual Health Reports*, *6*(3), 201–210. doi:10.1007/s11930-014-0026-6

Davidson, J. M. (1980). The psychobiology of sexual experience. In J. M. Davidson & R. J. Davidson (Eds.), *The psychobiology of consciousness* (p. 271-332). Springer.

Diambra, J. F., Pollard, B. L., Gamble, R. M., & Banks, B. P. (2016). Teaching a human sexuality course: What are counseling students thinking? *American Journal of Sexuality Education*, *11*(1), 76–91. doi:10.1080/15546128.2016.1141737

Dubray, S., Gérard, M., Beaulieu-Prévost, D., & Courtois, F. (2017). Validation of a self-report questionnaire assessing the bodily and physiological sensations of orgasm. *The Journal of Sexual Medicine*, *14*(2), 255–263. doi:10.1016/j.jsxm.2016.12.006

Dupkoski, W. (2012). Sexuality is universal: Implications for using a constructivist approach to sexuality training in counselor education programs. *Ideas and research you can use: VISTAS 2012*. Retrieved from https://www.counseling.org/Resources/Library/VISTAS/vistas12/Article_12.pdf

Fabre, L., & Smith, L. (2013). Effective treatment of major depression and accompanying sexual dysfunction. In F. J. Courtois (Ed.), *Sexual dysfunctions: Risk factors, psychological impact and treatment options* (p. 139-161). Nova Science Pub Inc.

Fisher, T. D., Davis, C. M., & Yarber, W. L. (2010). *Handbook of sexuality-related measures*. Routledge.

Hite, S. (1976). *The hite report: A nationwide survey of female sexuality*. Bloomsbury.

Jahoda, A., & Pownall, J. (2013). Sexual understanding, sources of information and social networks: The reports of young people with intellectual disabilities and their non-disabled peers. *Journal of Intellectual Disability Research*, *58*(5), 430–441. doi:10.1111/jir.12040

James, R. (2007). Strategies for incorporating women-specific sexuality education into addiction treatment models. *American Journal of Sexuality Education*, *2*(3), 3–25. doi:10.1300/j455v02n03_02

Juergens, M. H., Smedema, S. M., & Berven, N. L. (2009). Willingness of graduate students in rehabilitation counseling to discuss sexuality with clients. *Rehabilitation Counseling Bulletin*, *53*(1), 34–43. doi:10.1177/0034355209340587

Kazukauskas, K. A., & Lam, C. S. (2009). Disability and sexuality: Knowledge, attitudes, and level of comfort among certified rehabilitation counselors. *Rehabilitation Counseling Bulletin*, *54*(1), 15–25.

doi:10.1177/0034355209348239

King, R., & Belsky, J. (2012). A typological approach to testing the evolutionary functions of human female orgasm. *Archives of Sexual Behavior*, *41*(5), 1145–1160. doi:10.1007/s10508-012-0001-0

King, R., Belsky, J., Mah, K., & Binik, Y. (2010). Are there different types of female orgasm? *Archives of Sexual Behavior*, *40*(5), 865–875. doi:10.1007/s10508-010-9639-7

Kinsey, A. C., Pomeroy, W. B., Martin, C. E., & Gebhard, P. H. (1953). *Sexual behavior in the human female*. Indiana University Press.

Lenes, E., Swank, J. M., & Nash, S. (2015). A qualitative exploration of a music experience within a counselor education sexuality course. *Journal of Creativity in Mental Health*, *10*(2), 216–231. doi:10.1080/15401383.2014.983255

Levin, R. J. (2004). An orgasm is… who defines what an orgasm is? *Sexual and Relationship Therapy*, *19*(1), 101–107. doi:10.1080/14681990410001641663

Levin, R. J. (2014). The pharmacology of the human female orgasm — its biological and physiological backgrounds. *Pharmacology Biochemistry and Behavior*, *121*, 62–70. doi:10.1016/j.pbb.2014.02.010

Mah, K., & Binik, Y. M. (2001). The nature of human orgasm: a critical review of major trends. *Clinical Psychology Review*, *21*(6), 823–856. doi:10.1016/s0272-7358(00)00069-6

Mah, K., & Binik, Y. M. (2002). Do all orgasms feel alike? evaluating a two-dimensional model of the orgasm experience across gender and sexual context. *Journal of Sex Research*, *39*(2), 104–113. doi:10.1080/00224490209552129

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Little, Brown.

National Board for Certified Counselors. (2012). *Graduate student ncc application.* Author. Retrieved from https://www.nbcc.org/Assets/StudentTipSheet.pdf

Newcomb, M. D., & Bentler, P. M. (1983). Dimensions of subjective female orgasmic responsiveness. *Journal of Personality and Social Psychology*, *44*(4), 862–873. doi:10.1037/0022-3514.44.4.862

Warner, J. E. (1981). *A factor analytic study of the physical and affective dimensions of peak of female sexual response in partner-related sexual activity* (Unpublished doctoral dissertation). Columbia University.

Wimpissinger, F., Springer, C., & Stackl, W. (2013). International online survey: female ejaculation has a positive impact on women's and their partners' sexual lives. *BJU International*, *112*(2), E177–E185. doi:10.1111/j.1464-410x.2012.11562.x

Zeglin, R. J., Dam, D. V., & Hergenrather, K. C. (2017). An introduction to proposed human sexuality counseling competencies. *International Journal for the Advancement of Counselling*, *40*(2), 105–121. doi:10.1007/s10447-017-9314-y