Clinical Implications in Vaginal Orgasm Response

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Clinical Implications in Vaginal Orgasm Response

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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; Kazuakuskas & 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). Duplic
male, stimulation of di-
ology, as well as emotional components (Hite, 1976). Several
their orgasms di-
orgasm, no matter how it is brought on or by whom. Contrary
Stackl, 2013). King and Belsky (2012) reported this as the
broaden the def-
Previous literature suggested that all vaginal orgasms are
basically the same (King, Belsky, Mah, & Binik, 2010). How-
however, the idea that there are variations between vagi-
orgasm, clitoral orgasms has been under-researched,
variations between vagi-
orgasm. Unlike the 2011 study, however, this study helps to
provides insight on the physiological sensations achieved
during orgasm by utilizing the Bodily Sensations of Orgasm
(BOSO) questionnaire first published in 2017 (Dubray et al.,
We hypothesize that participants will report experienc-
more than one kind orgasm as previous literature has
demonstrated that these different experiences will be
Identified in participants who report experiencing orgasm
through masturbation versus participants who report experi-
encing orgasm through sex with a partner. Participants were
divided into these groups based upon previous studies ex-
amining biopsychosocial models of orgasm experience that
speculate orgasm is comprised of both physical and psycho-
logical/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) re-
port experiencing different vaginal orgasm experiences
during masturbation and sex with a partner. We hypothesize
that these orgasm experiences will vary between both physiolog-
ical and psychological responses.

**Methods**

**Participants**

The participants for this study included 369 cisgender
women and gender non-conforming individuals with vagi-
as. 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 Uni-
versity of the Cumberlands. Individuals were recruited to
participate by social media or email invitation. All informa-
tion gathered for this study was anonymous and completely
voluntary. Participants confirmed that they had either ex-
perienced 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 = 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 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, η² = 0.05. There was a statistical significance found for ‘choppy/shallow breathing (apnea)’ between the two groups, F(6, 362) = 3.436, p = .003, η² = 0.05. There was a statistical significance found for ‘shivers/goosebumps’ between groups, F(6, 362) = 2.842, p = .011, η² = 0.04. There was a statistical significance found for ‘hypersensitive clitoris’ found between the two independent groups, F(6, 362) = 3.210, p = .004, η² = 0.05. There was significant difference found between groups for ‘flowing,’ F(6, 362) = 2.137, p = .049, η² = 0.03. There was also a significant difference found between the two independent groups for ‘vulvar pulsations,’ F(6, 362) = 2.405, p = .048, η² = 0.03. For psychological sensations, there was a significant difference found for ‘trembling’ between independent groups, F(6, 362) = 2.647, p = .016, η² = 0.04, as well as ‘spurting,’ F(6, 362), p = .005, η² = 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
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

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

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

<table>
<thead>
<tr>
<th>Scale</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
</table>
| 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.

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

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


