

# <sup>67</sup> From Arousal to Afterglow: Female Orgasm, Ejaculatory Fluids, and Holistic Intimacy

Understanding female orgasm requires bridging physiology, psychology, and relational context. Contemporary research reveals that women can experience diverse orgasmic phenomena – from strong clitoral or vaginal climaxes (sometimes multiple in one session) to urethral emissions (“squirting” or true ejaculation). Critically, two distinct fluids can be expelled: a small, milky “female ejaculate” from Skene’s (paraurethral) glands containing prostate-specific antigen (PSA), and a larger-volume clear “squirting” fluid that is essentially diluted urine. Real-time imaging (ultrasound) shows that high-volume squirting is typically preceded by bladder filling and followed by bladder emptying at climax. In contrast, true ejaculate is released in small amounts independent of bladder volume and is rich in PSA/PAP. These findings indicate **two fluid sources**: a prostate-like gland secretion (the “female prostate”) vs. involuntary bladder emptying.

## Figure:

*Diagram of female genital anatomy (clitoral glans and bulbs, vaginal canal with G-spot area, and paraurethral/Skene’s glands highlighted)*【72†】. This anatomy underlies orgasmic experience. Orgasm typically involves surges in blood pressure, heart rate, and breathing, plus rhythmic contractions of pelvic muscles (often sensed as vaginal muscle spasms). Neuroendocrinologically, climax triggers spikes in catecholamines (adrenaline/noradrenaline) and a pronounced release of prolactin lasting ~60+ minutes. Oxytocin – the “bonding hormone” – often rises around orgasm and especially in the post-sex “afterglow,” though recent home-based studies find oxytocin peaks 20–40 min after sex and can synchronize between partners. High oxytocin levels at afterglow likely facilitate emotional closeness and trust.

## Ejaculatory Fluids: Squirting vs. Female Ejaculation

- **Female ejaculate (Skene’s secretion):** A *low-volume* (often a few milliliters) milky fluid produced by paraurethral (“Skene’s”) glands. It contains PSA/PAP and sugars, resembling a prostatic secretion. This fluid may be expelled coincidentally with orgasm or intense arousal, without involving the bladder.
- **Squirting:** A *high-volume* (tens of milliliters) clear fluid expelled from the urethra during intense sexual stimulation or orgasm. Biochemical analyses show squirting fluid’s urea/creatinine content matches urine, and ultrasound confirms it comes from the bladder. However, up to ~70–80% of squirts’ fluid may contain small PSA amounts, suggesting minor Skene’s contributions. In sum, **squirting is predominantly reflexive urination linked to orgasmic contractions**, whereas **female ejaculation is a separate glandular emission**.

Research (Salama et al., 2015; Inoue et al., 2022; Pastor & Chmel, 2018, 2022) emphasizes this distinction. For example, one ultrasound study tracked 7 women through orgasm: all showed bladder emptying at squirting, and their expelled fluid chemistry was essentially urine (urea, creatinine). A later study dyed the bladder fluid and again found the discharged fluid to be bladder origin. By contrast, female ejaculate is proteinaceous and PSA-rich – confirming a “female prostate” origin. In practice, many women report that bearing-down or “pushing” through pelvic relaxation triggers squirting, consistent with a Valsalva-like expulsion mechanism rather than a simple increase in orgasm intensity. Open questions remain about individual variability (e.g. Skene’s gland size or urethral sphincter tone) and how pelvic-floor mechanics coordinate these emissions.

## Orgasmic Modalities and Diversity

Women’s orgasms vary by site and experience. **Clitoral orgasms** (from external glans stimulation) are the most common, involving rich somatic (pudendal nerve) input. **Vaginal or G-spot orgasms** (anterior vaginal wall) may recruit deeper pelvic plexus and even vaginal pathways; some women feel these as distinct from clitoral climaxes. **Blended orgasms** combine clitoral and vaginal input simultaneously. Some women also report **cervical orgasms** via deep cervical stimulation. Importantly, women can often experience multiple orgasms in succession (no refractory period like men), though this varies individually.

Sexual response is strongly **influenced by context**. Contemporary models (e.g. Basson’s circular model) highlight that female desire can be *responsive* – emerging from intimacy, arousal, and context rather than only spontaneous drive. Women’s arousal depends on emotional safety and arousal cues. Shame or trauma (e.g. from “purity culture”) can inhibit the ability to relax into arousal, potentially causing tension or “spectatoring” anxiety. One behavioral health source notes that Christian purity teachings often instill *“immense sexual shame and guilt”* about natural desire, which in turn can lead to performance anxiety or even genophobia. Overcoming such shame requires reframing sexuality as natural and mutual, as discussed below.

Cross-cultural surveys show that orgasm frequency and the value placed on female pleasure vary worldwide. For instance, a large U.S. study found marked ethnic differences: Asian women reported lower orgasm rates, while Hispanic/Latina women reported higher rates, likely reflecting cultural norms (e.g. acceptability of oral sex, attitudes toward female pleasure). This suggests that beliefs and education significantly affect orgasm accessibility.

**Cycle and Hormones:** Many women notice cyclical patterns. Estrogen peaks mid-cycle tend to boost libido and lubrication. In fact, desire often rises in the days before ovulation and wanes in the late luteal phase. Anatomical changes (e.g. cervical height, clitoral engorgement) may also alter sensations. Thus, tailoring timing (and using extra lube postpartum/menstrually) can enhance pleasure.

## Couple-Based Stimulation Protocols

Couples can use structured protocols to improve arousal, orgasm probability, and intimacy. Key elements include the **sequence of stimulation modalities**, **tempo/pacing**, and **mutual cues**. Research and clinical experience suggest several effective patterns:

- **Clitoral-First (Suction) Protocol:** Start with powerful clitoral stimulation (e.g. a Womanizer or suction device). These devices use pulsating air pressure to engorge the clitoris without numbing it, often producing very fast, intense orgasms even in orgasmically naïve women. In one clinical pilot, 100% of menopausal women with orgasm difficulty reached climax within ~10 minutes using a Womanizer. *Proposed Sequence:* Use a Womanizer on high intensity until she reaches a strong clitoral orgasm, then pause (~30–60s) to let her stabilize. After the brief break, transition to intercourse (e.g. missionary with coital alignment) or continued manual/oral stimulation. This “peak-break-peak” pattern can often yield a second (vaginal-blended) orgasm. (Some therapists even advocate allowing the husband to climax first in a controlled way, then fully focusing on the wife – a “sacrificial orgasm” strategy – so his refractory period aligns with her second orgasm.)
- **Blended Stimulation Protocol:** Begin with combined clitoral plus G-spot stimulation. One partner uses a finger or toy on the anterior vaginal wall (the so-called G-spot) while simultaneously stimulating the clitoris (e.g. oral sex plus finger). This can rapidly build internal pressure. Once very close, shift to intercourse or continue manual stimulation allowing simultaneous or back-to-back orgasms. For women who experience squirting, firm rhythmic G-spot massage – *especially after an initial clitoral orgasm or heavy arousal* – often precipitates emission. Hydrating beforehand and emptying the bladder first are pragmatic steps (since a full bladder tends to squirt at climax).
- **Coital Alignment Technique (CAT):** For maximizing coital clitoral stimulation, the “raised missionary” position of CAT is empirically effective. In CAT, the couple aligns so that the man’s pubic bone rubs continuously against the woman’s clitoris during intercourse. Research describes CAT as “consistent and effective stimulation for female coital orgasm”\*. Thus, after foreplay and clitoral priming, shifting into CAT (often with the man erect and kneeling between her legs while she lies flat) can help her reach orgasm during penetration.
- **Alternate Positions:** Studies show that positions with the woman on top or kneeling (face-to-face female above, rear-entry kneeling) are among the most pleasurable. In fact, women who frequently use face-to-face (woman on top) report significantly higher rates of orgasm during intercourse. Couples can experiment: cowgirl (woman on top facing him), reverse cowgirl, or kneeling from behind (doggy style) can enhance angle and clitoral stimulation depending on anatomy.

Overall, **pace matters**. Partners should communicate verbally (e.g. “harder/softer, faster/slower”) and watch for physical cues. A useful rule is to “lock in” once the woman is on the verge of orgasm – abrupt changes can knock her out of the peak. Encouraging alternating rhythms (long slow strokes vs. short quick ones) and paying attention to her feedback optimizes timing. Involving toys can be very helpful: for example, inserting a clitoral vibrator during intercourse or switching from oral to a Womanizer at the final stretch.

## Afterglow Practices

Post-orgasm closeness (“afterglow”) is integral. Many sex educators and studies highlight the value of affectionate rituals. For example, *mutual eye-gazing* for even a minute or two releases oxytocin and phenylethylamine, hormones associated with bonding. Classic studies show that partners who gaze into each other’s eyes experience significant increases in feelings of trust, intimacy, and attraction. Cuddling, hugging, and gentle caressing while gazing can amplify this effect. Indeed, a recent real-world study found couples’ oxytocin levels tend to synchronize 20–40 minutes after sex, supporting the idea that “affectionate behavior after sex is associated with higher relationship satisfaction”\*.

Couples may incorporate brief spoken rituals: saying “I love you,” sharing compliments, or even a short prayer of gratitude together. (Some report that praying right after orgasm, when oxytocin is high, feels particularly bonding.) Mindful touch exercises – e.g. placing hands on each other’s heart or back while breathing together slowly – can turn the moment into a deeply connective experience. These practices not only feel good, they help “cement positive memories” which fuel desire and intimacy long-term.

## Psychological, Relational, and Individual Factors

**Communication and Emotional Safety:** A woman’s ability to relax into orgasm depends heavily on feeling safe, desired, and emotionally connected. Therapists emphasize that shame or performance pressure are libido-killers. Open communication (before and during sex) about preferences and comfort can build that safety. For example, couples can use empathetic “feedback loops”: one partner might say, “That feels great” or “Can you do X?” as cues. Learning to speak one’s needs as “I want...” fosters a positive atmosphere (cf. Gottman’s “soft start-ups” and “dreams within conflict”).

**Fantasy and Novelty:** Erotic anticipation can be maintained through novelty or fantasy (see Est. Perel’s work). Planning a special “date night” with mood setting, lingerie, or reading erotic literature together can rekindle excitement. Introducing sex toys (e.g. the Womanizer, vibrators, lubricants) or trying new positions in a spirit of play often improves arousal. Fantasy or erotic narratives (spoken fantasies, role-play) may also help overcome mental distractions.

**Impacts of Fatigue and Chronic Illness:** Conditions like MS or postpartum fatigue can dampen sexual response via multiple pathways. MS specifically often causes reduced sensation and orgasm difficulty, plus fatigue and depression that lessen libido. Likewise, new parents deal with sleep deprivation and body changes. For these couples, **efficiency is key**. Shorter, high-intensity stimulation (e.g. 2–6 minutes with a Womanizer) can compensate for low energy, making orgasm still attainable. Being strategic – scheduling sex when she feels best (e.g. after rest, on high-estrogen days), prioritizing foreplay that works quickly, and using lubricants to offset any dryness – helps maintain satisfaction despite fatigue. Emotional support and empathy (e.g. praising her efforts, taking pressure off immediate orgasm success) are also vital.

**ADHD and Attention Differences:** For partners with ADHD or high distractibility, structure can help. Agreeing on a fixed sequence (e.g. clitoral first, then X step) and using clear, concise cues (“Now I’m going to insert two fingers”) may keep both in sync. Overstimulation or abrupt changes might disrupt focus, so transitions should be signaled. Some couples find

that a brief “signal code” (like gently squeezing a hand) communicates closeness or climax impending without words, reducing anxiety.

**Sensitivity and Variation:** Every body is different. Some women have very sensitive clitorises and require lighter touch (or more use of a hooded approach), others need firm pressure. Similarly, internal sensitivity to G-spot pressure varies. A helpful general rule is: “If she’s hiding (clitoris retracts) you may be overstimulating; if it’s engorged and peeking, the current level is good.” Experimentation will reveal which speeds and pressures she finds pleasurable.

## Christian Marriage and Spiritual Integration

For Christian couples, marital intimacy is not only biological but sacramental. Many Christian teachings – from the Bible’s Song of Songs to modern theology – affirm that God designed marital sex to be a mutual gift of self filled with joy. Catholic and Orthodox theology (John Paul II’s “Theology of the Body”) explicitly calls marital intercourse the spouses’ \*\*\*“total gift of self”\*\*. In this view, joyful erotic pleasure in marriage reflects the Trinitarian communion of love and is inherently good (even if unitive and procreative meaning often coexists). The Song of Solomon, for example, is celebrated as poetry that valorizes passionate marital love. Thus, sharing diverse forms of orgasmic intimacy can be seen as a covenantal act that glorifies God’s gift of sexuality.

In practice, faith-aligned guidance means emphasizing mutual respect and consent (as 1 Cor. 7:3–5 suggests each spouse’s sexual needs are gifts to be given). It also means encouraging couples to reject legalism or shame (e.g. about oral sex or use of toys) that has no clear scriptural basis, focusing instead on the spirit of mutual service and delight. Many Christian sex therapists (e.g. Monica Cook, Sheila Gregoire) work to **reconcile spirituality with erotic exploration**: they advise that playfulness, variety, and even novelty (within agreed boundaries) are acceptable and can deepen connection under Christ’s love.

## Practical Toolkit: Exercises and Rituals

- **Orgasmic Diversity Exercises:**

- *Clitoral Exploration:* Guidetouch mapping. The wife can lie comfortably, the husband and wife exploring the clitoris together – testing light stroking, vibration, suction – to identify what feels best at each stage. The woman might take control (using her own toy or hand) while he watches/supports, then switch. The goal is discovering her most responsive spots and pressures.
- *G-Spot Massage:* During foreplay, one partner inserts 1–2 fingers into the anterior vaginal wall (about 2–3 inches deep) and makes a “come-hither” motion. Simultaneously, or alternately, the clitoris is stimulated externally (e.g. with a vibrator or tongue). Practice gradually increasing intensity. Pay attention to sensations – some women may feel increased pelvic pressure or a need to urinate before squirting. Experiment with different angles and rhythms.

- *After-Orgasm Bonding:* After sex, spend 1–2 minutes gazing into each other’s eyes (no pressure for new orgasm). During this gaze, each partner might say one thing they loved or appreciate (“That felt so good when...”). A short prayer of thanksgiving (e.g. “Lord, thank you for bringing us so close today”) can be included if comfortable. Alternatively, lie chest-to-chest, feeling each other’s heartbeats and breathing slowly together. These practices harness the natural oxytocin surge to reinforce emotional intimacy.
- **Communication Playbook:**  
Use positive, nonjudgmental language for desires and boundaries. For example, frame requests as personal pleas (“I’d love it if you...” rather than criticisms). Have an “after-action review” talk at a calm time: each can share what felt amazing or what they’d want more of next time. Ask open-ended questions like, “Was there anything you loved or didn’t love?” to invite honest feedback. Avoid blame; emphasize teamwork (“Let’s figure this out together”). Scripture encourages kindness and patience – apply these in discussions too.
- **Ritualized “Date” Exploration:**  
Designate a regular intimate night free from distractions (no phones/kids). Build anticipation: maybe send playful texts earlier, use candles or music to set the mood, or read a sensual passage from Song of Solomon. Try new techniques on these nights (e.g. a new toy, a blindfold to heighten sensation, or erotic massage). Afterward, share a dessert or a quiet moment reflecting on the experience. This not only keeps playfulness alive but anchors erotic growth in a loving relational context.
- **Fatigue-Aware Short Protocols:**  
For low-energy days (e.g. MS fatigue or new baby), shorten foreplay to the most effective components. Using a powerful clitoral stimulator for 5 minutes may succeed where 30 minutes of manual foreplay would not. Keep things warm and well-lubricated to reduce unnecessary effort. Ensure the bed is easy to access (e.g. remove obstacles) and have pillows for support. A quick “cuddle session” breathing in sync before or after can amplify the connection without draining too much energy.
- **Individual Differences:**  
If one spouse (e.g. Josh) has ADHD, keep instructions simple and visual cues (like a gentle tap) handy to signal transitions. If one is very sensitive (e.g. Kristy’s MS might heighten sensation), watch for overstimulation signs (e.g. flinching or pulling away) and adjust. Partners should reassure each other and celebrate any progress, no matter how small, to build confidence and reduce anxiety.

## Evidence Summary and Future Directions

This integrated approach draws on sexology research (urodynamics, endocrinology, device trials), psychology (models of desire and intimacy, effects of shame), and theology (the marital gift-of-self paradigm). An evidence map would cite the above sources in detail. Key points include: the bladder origin of squirting (so screening for incontinence issues), the role

of oxytocin in afterglow bonding, and the very high efficacy of suction stimulators in orgasmic facilitation.

Clinically, these findings suggest multi-modal assessment (bladder scans, hormone sampling, psychometric scales) combined with couple-based trials of protocols. For Josh and Kristy specifically, tailoring techniques to Josh's high drive and Kristy's fatigue and sensitivity (e.g. alternating who leads stimulation, using a Womanizer first, scheduling short "quickie" sessions) can level the playing field. Alongside, continuing conversation about their faith values will ensure all practices feel "covenant-honoring."

In summary, achieving orgasmic consistency and deeper intimacy is a couple's journey involving biology, technique, communication, and shared meaning. By leveraging what science knows about female orgasm (including the truth about squirting), applying structured stimulation sequences, and nurturing afterglow connection (both emotional and spiritual), couples can expand their sexual fulfillment and marriage satisfaction over time. With ongoing dialogue and experimentation guided by mutual respect, Josh and Kristy can cultivate a rich erotic life that is joyful, consensual, and aligned with their deepest values.

**Sources:** Multidisciplinary research has informed this synthesis. Each assertion above is grounded in empirical or expert sources as cited.