NOVEMBER 8-9, 2025

VIRTUAL

MEN'S PELVIC HEALTH SUMMIT

CLINICAL SUMMARY

SEX-POSITIVE INFORMED MENTAL HEALTH FOR PELVIC HEALTH PROVIDERS

PRESENTED BY DR. COURTNEY FRASER, LPC, PHD

DAY 1 • SESSION 3

CLINICAL SUMMARY

Overview

This presentation explores the intersection of mental health, sexual health, and pelvic pain in men through a sex-positive informed lens. Dr. Fraser highlights common mental health diagnoses that show up alongside pelvic floor dysfunction and sexual concerns, how these issues may present in pelvic therapy, clinical red flags for referral, and practical tools to maintain scope while supporting patient care.

Key Clinical Themes

Common Mental Health Diagnoses

Anxiety: The most prevalent issue, presenting as worry, perfectionism, avoidance, or emotional flooding.

Trauma: Viewed through a nervous system lens, not just the narrative of what happened. Includes medical, relational, and developmental trauma.

OCD and Body Dysmorphia: Often missed in pelvic health contexts; compulsions may be mental (e.g., rumination, chronic avoidance). Body dysmorphia often involves obsessive concern over genital appearance.

Neurodivergence: Sensory sensitivities and processing differences must be factored into treatment plans.

Depression: Commonly secondary to unresolved pelvic pain or sexual dysfunction. Symptoms include low energy, motivation, and decreased interest in care.

Out-of-Control Sexual Behavior (OCSB): A sex-positive alternative to the "sex addiction" label. Emphasizes regulation challenges rather than pathology

Clinical Presentation in Pelvic Therapy Settings

How These Conditions Show Up

Anxiety: May present as excessive worry, difficulty with uncertainty, or strong fear of doing exercises "wrong."

CLINICAL SUMMARY

OCD: Patients may show rigidity, perfectionism, excessive reassurance-seeking, or resistance to exercises due to fear of physical or emotional harm.

Trauma Responses:
• *Freeze:* Emotional shutdown, blank stare, dissociation.
• *Fawn:* Over-accommodation, passivity, or avoidance of discomfort to "keep the peace."

Neurodivergence: Overstimulation, distress during sensory-heavy or unpredictable treatments.

Key Terms

Sexual Dysregulation: The use of sexual behaviors to self-soothe or regulate nervous system states. May increase pelvic tension or pain if over-relied upon.

OCSB Model: Emphasizes emotional regulation and context over pathology. Useful when patients describe being "addicted" to sex, porn, or masturbation.

Arousal Non-Concordance: A mismatch between genital response and psychological arousal. Occurs in roughly 50% of men and is not inherently sexual or inappropriate.
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Arousal and Boundaries

Navigating Genital Responses in Session

• Unwanted erections and ejaculation responses can happen and are often physiologic, not sexual.

• Normalize responses calmly and professionally. Educate patients on the body's arousal systems, especially when distress is present. *Example: "This can happen. Your body has automatic responses. Let's pause here and give you privacy, then we can check in."*

When Arousal Becomes a Red Flag

• Repeated boundary-pushing, voyeuristic disclosures, or disregard for provider discomfort may signal a need for referral.

• If you feel persistent discomfort — what Dr. Fraser refers to as "the ick" — take that as clinical data.

CLINICAL SUMMARY

Relational Dynamics and Professional Boundaries

Transference and Countertransference

• ***Transference:*** The patient unconsciously projects past relational patterns or emotions onto the provider (e.g., emotional dependence, idealization, flirtation).

• ***Countertransference:*** The provider's emotional response to the patient. Useful for identifying when to reestablish or adjust boundaries.

Boundary Management

• Boundaries are grounded in clinician needs and expectations, not behavior control.

• Clarify boundaries using non-defensive language. *Example: "I don't talk about my personal life. That helps me stay focused on your care and what's best for you."*

Practical Communication Strategies

The VEA Framework
Validation + Encouragement + Accommodation

• Validation: Acknowledge their fear or distress without judgment.

• Encouragement: Gently invite engagement in care despite fear.

• Accommodation: Offer an adjusted recommendation that feels doable.

Example: "It makes sense that you're afraid of doing this wrong. I believe this exercise will help. Would it feel more manageable to start with just twice a week?"

Example: "It makes sense that you're scared to try the exercises. The exercises I've given you will help you in the long run. I feel confident about that, and I know you're scared to try them, but I think if you do try, we're going to be likely to see some progress."

Example: "It's totally understandable that you'd want to avoid sex with your partner. But what we do know is the more we avoid sex, the more likely we can stay stuck. So what would it look like to try talking with your partner about what you'd both like sex to look and feel like?"

Radical Acceptance

Acknowledging reality without judgment helps both patients and clinicians shift from rumination to forward movement. *Example: "You're in pain, and it's interfering with what you love. That's real. Let's look at what we can do differently from here."*

CLINICAL SUMMARY

Red Flags That Warrant Mental Health Referral

- Freeze or fawn responses during care (e.g., dissociation, over-accommodation).
- Mismatch between solo and partnered sexual function.
- Recurrent, shame-based unwanted erections with distress or inappropriate behavior.
- Resistance to care due to fear, perfectionism, or compulsive thinking.
- Disclosures of suicidal ideation or hopelessness.
- Boundary-pushing after redirection (e.g., inappropriate disclosures, repeated personal questions or remarks).
- Persistent discomfort on the part of the provider.

Scope Awareness and Staying in Your Lane

Do Not:

- Try to unpack trauma or relational dynamics.
- Dive into childhood abuse histories or attachment wounds during pelvic therapy care.
- Attempt to "solve" mental or emotional roadblocks to treatment.

Do:

- Acknowledge what you're hearing.
- Normalize their experience.
- Refer to trained professionals with clear, respectful language. *Example: "That sounds like a lot to carry. I know a great therapist who can help unpack this in a way I can't."*

Referral Scripts and Resistance

If a Patient Declines Referral: *Example: "You're free to make the choices that feel right to you. At the same time, I want to be upfront about my scope. There may be other contributors to what you're feeling that are outside of what I'm trained to address. I want to be transparent so you can get the most out of your care."*

Example: "We've done great work together, and I wonder if we're at a point where someone with a different perspective could help move things forward."

Clinical Takeaways

- Validation reduces nervous system threat responses and supports engagement.
- Boundaries protect therapeutic integrity and foster trust.
- Scope discipline is not a lack of care — it's a clinical strength.
- Collaboration between pelvic health therapists and mental health providers leads to better outcomes.
- Your professional discomfort is information. If something feels off, reflect, reassess, and consider referral.