NOVEMBER 8-9, 2025

VIRTUAL

MEN'S PELVIC HEALTH SUMMIT

CLINICAL SUMMARY

HOLDING AROUSAL WITHOUT FEAR: A NEW SKILLSET FOR PROVIDERS

PRESENTED BY ERICA LEROYE, M.ED, CSB

DAY 1 • SESSION 6

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Overview

In this reflective and practical session, Erica Leroye explores how providers can expand their capacity to ethically and compassionately hold space for arousal during therapeutic care. She reframes arousal not as a risk or threat but as a natural and assessable physiological state—just like breath, gait, or grip. The conversation centers on creating safer, clearer, and more comfortable therapeutic environments for clients and practitioners alike, especially when working with genital tissues and sexual function in men.

Key Clinical Themes

The Arousal Conundrum

• The arousal conundrum is the paradox that, while pelvic health providers are expected to assess and treat dysfunction in the arousal system (just like any other physiological system), they are often unable—or unwilling—to observe that system functioning in real time due to fear, shame, scope concerns, or lack of training. Arousal is often excluded from therapeutic settings, despite being part of a core physiological system. Providers regularly assess bodily systems "in action"—but this doesn't typically extend to sexual function.

"If someone comes to me and says, 'When I'm playing tennis, there's something going on with my backswing,' I can say, 'Show me the movement…' But the moment it's pain with erection or ejaculation… this is the only part of the body that we can't actually look at in action."

• Erica argues that this creates a clinical and ethical dilemma: how can we assess, treat, and normalize the arousal system if we're afraid to see it function?

• The "conundrum" is not about whether arousal occurs—it's about the discomfort, avoidance, and inconsistency with which providers approach it, despite treating the very system it arises from.

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Common Provider Fears: Erica identifies three main fears that limit providers' ability to work confidently with arousal:

Competence: Lack of training or fluency with genital anatomy, physiology, or arousal response, especially among providers without penises.

Scope and Liability: Legal and ethical uncertainty around touching the penis or working with tissue beyond pelvic musculature.

Personal Triggers: Providers' own unexamined experiences with sex, arousal, gender, or trauma may lead to fear or discomfort. *"If I allow arousal to be here, it might trigger a bunch of things inside myself that I'm not ready for."*

Language, Comfort, and Embodied Practice

• Language is a clinical skill. Providers must build comfort saying terms like "masturbation," "dildo," "orgasm," "butt plug."

• Embodied exploration (e.g., practicing with a strap-on or flaccid packer) helps build literacy when providers do not have the anatomy themselves.

• Comfort is a felt sense and providers should somatically track their own internal responses to sexual words, images, and situations.

Practical Clinical Strategies

Begin with the Body

• Invite clients to adjust for comfort at the start of sessions—including genital comfort.

• Include the entire body—genitals, belly button, anus, shoulders, ears—as welcome in the room. *"My labia is a little stuck... my penis is a little torqued... my anus is clenched."*

Regulate Power Dynamics

• Erica likes to use the kink framework of topping and bottoming to frame session dynamics energentically.
  - **Topping**: Provider leads, guides, contains, and defines the space with clear boundaries and props.

• Clarify consent and roles: *"You don't have to do anything back. You just get to receive and feel."*

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Normalize Spontaneous Arousal

• Name arousal openly: erections, fluid release, and tissue changes are expected and non-threatening.

Establish shared agreements:

- *"If this happens and you feel uncomfortable, we'll use a timeout word."*
- *"If I feel uncomfortable, I'll express my boundary because I have a boundary that I need to be clear about. It's not about shame."*

Document Clearly and Upfront

If inviting arousal (vs. simply allowing it), written agreements should include:

- What's being done
- Why it's being done
- Clear "pause" or "stop" points

Inviting Arousal: Arousal as Diagnostic

• Use arousal-oriented touch (e.g., soothing, oxytocin-releasing touch) to assess tone, breath, emotional safety, and fascia response. *"Let's see how your oxytocin system responds."*

• Observe changes with touch: *"Notice what feels different now than when we started."*

• Offer sensory stimulation (without requiring provider touch):

- Client-guided touch using silk, velvet, nylons
- Music that evokes positive, pleasant, playful or sexual memories
- Aromatherapy for sensory integration, neural-soothing.

"Let them self-pace their arousal, where you can be more of an observer."

Scope, Referrals, and Boundaries

• **Sexological Bodyworkers** can provide hands-on genital bodywork (one-way, gloved, clothed practitioner).

• **Somatic Sex Educators** focus on body-based sex education, typically without touch.

• **Surrogate Partners** may engage in mutual touch or intercourse as part of therapeutic triads with a mental health provider

"It's totally fine to say this is not what I'm comfortable with, and there are people out there to support you."

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Closing Reflections

• Welcoming arousal allows providers to gather exponentially more diagnostic • information.

• When providers meet clients with safety and clarity, clients may experience vulnerability, regulation, and emotional repair.

"Every time I am in the room with a penis, and I have the opportunity to make it feel seen and allow the body to be heard... there's still capacity for pleasure."