NOVEMBER 8-9, 2025

VIRTUAL

MEN'S PELVIC HEALTH SUMMIT

CLINICAL SUMMARY

EROTIC EMBODIMENT PRACTICES FOR PENIS PLEASURE

PRESENTED BY DR. KATHRYN ELLIS, OTD, OTR/LC, CSOT, FAOTA

DAY 1 • SESSION 2

CLINICAL SUMMARY

Overview

Dr. Ellis reframes sexual health assessment for penis owners: "the lack of pleasure is the dysfunction." Pleasure is both measurable and functional—"a felt sense of pleasure or anticipation of pleasure is what brings the blood flow and keeps the erection going." Pleasure processing requires a parasympathetic state; when pleasure is disrupted, the physiological process (including erection) breaks down. She offers clear language, boundaries, and practical embodiment tools (breath–movement–sound) to build mind–genital connection within pelvic therapy scope, while normalizing arousal responses and integrating consent throughout care.

Key Clinical Themes

Pleasure as a Clinical Measure

• Lack of pleasure or pleasure awareness is a sensory disruption, not just a psychological issue.
• Treat pleasure like any other functional metric tied to patient goals.

Ask About Pleasure (Start Simple)

"We gain so much information and data from asking about pleasure."

Entry questions:

"What are you focusing on during sex?"
"What feels pleasurable during sex?"
"Where on your body are you feeling the most pleasure?"

• Answers show whether attention is on a partner, in performance thoughts, penis-focused, or embodied in their pleasure experience. **"***Leaving pleasure out of the conversation is... like [treating] incontinence and we're not gonna talk about peeing."*

Interoception → Mind–Genital Connection

Interoception = felt inner sense (e.g., need to urinate, feeling hot, feeling aroused).
OT/PT skills for mind–body rehab translate directly to mind–genital rehab.

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Boundaries, Consent, and Normalization

• Invite consent explicitly and repeatedly.

• Prepare clients: *"It's not uncommon to have an erection. It's totally okay if you do or if you don't."*

• Clarify arousal vs. attraction; therapy focuses on arousal as a bodily process.

• Emphasize one-way touch: clinician → client; client receives, notices, and learns.

Collaboration and Roles

• **Somatic Sexological Bodyworker:** one-way touch for education/awareness; goal is learning, not gratification.

• **Somatic Sex Educator:** additional training beyond sexological bodywork.

• **Surrogate Partner:** bidirectional touch to practice touch/relational skills with clinical goals over a
defined period.

• **Sex work** is distinct (not necessarily anchored to clinical goals).

Practical Clinical Strategies

The Breath–Movement–Sound Framework

Breath

• Start with diaphragmatic/360° belly breathing; cue longer inhales/exhales.

• Guide pelvic-floor awareness with "butthole breathing": inhale = expansion, exhale = slight contraction.

• Avoid overpowering glutes: *"We do not want the glutes to fire… they're gonna overpower everything."*

• Helpful cues: "nuts to guts," or a gentle squeeze/lengthen along the scrotal seam (midline).

• Rationale from session: pelvic floor acts like a pump; gentle oscillation supports blood inflow and carries away lymphatic fluid that can "get in the way of arousal."

Movement

• Replace rigid thrusting with slow circular/gyrating pelvic motions to increase blood/lymph flow and pro-prioception.

• Keep glutes secondary so the brain doesn't "switch to squats."

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Sound

• Mouth/jaw are *"deeply connected with the genitals."*

• A *"long guttural moan"* supports vagal activation, vibration, arousal, and exhalation.

• Many clients are silent; invite any comfortable sound.

In-Session Integration Flow

1. Permission & Framing: *"Based on your goals, it's appropriate to talk about pleasure, erection, and arousal—OK to ask you about these?"*

2. Normalize & Contain: Acknowledge awkwardness up front. Dr. Ellis: she "*names it every single time,"* which *"gives the awkwardness less power."*

3. Sensory Mapping: During manual work, pair breath cues with sensory tracking: "*What do you notice here—pleasant, neutral, or not pleasant?"*

4. One-Way Touch Emphasis: Invite receiving without performance or reciprocation.

5. Functional Bridge: After touch, add movement patterns relevant to sex/masturbation positions, reinforcing proprioception and circulation.

Home Practice (Clinician Script)

"Take three slow breaths into your belly.

On your inhale, let your pelvic floor drop; on your exhale, gently draw it in.

Let your pelvis make a small circular motion.

Exhale with a soft sigh or hum.

Notice any warmth, tingling, or softening in your genitals.

Nothing to fix—just notice what feels alive."

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Clinical Framing, Language, and Documentation

Language that reduces pressure: focus on *"supporting your body's capacity for arousal and pleasure,"* not just *"improving erection quality."*

Use clear anatomical terms (penis, scrotum, shaft, base, head) to model sex-positive professionalism.

Validate frustration/shame directly: *"That sounds really frustrating... that stinks."* Dr. Ellis: *"Shame cannot survive in the light."*

Consent & Relevance Checks: Ask, *"Is this important to you?"* and *"Do you want to talk about it?"* Clients can opt in or pass.

Charting ideas: interoceptive awareness, attention focus (partner/performance/body), pelvic floor tension vs. oscillation, comfort discussing pleasure, tolerance of breath–movement–sound, and client-reported changes in arousal/pleasure.

Sensory Retraining Perspective

Frame pleasure exploration as sensory rehabilitation and graded exposure for clients reporting numbness, diminished sensation, or timing concerns.

Track shifts from external/performance focus to embodied genital sensation as an outcome.

When to Collaborate/Refer

• Desire for mutual/partnered touch practice → surrogate partner (bidirectional touch with goals).

• Expanded erotic learning/communication or deeper embodiment goals → somatic sex educator/sexological bodyworker.

• Continue pelvic therapy for relaxation, circulation, interoception, and functional integration.