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Erotic Felt Sense as a Clinical Innovation: Erotic Embodiment, Creative Expression and Storytelling for Holistic Sexual Health

Bridget Scholes

Master of Sexology, Independent Sexologist and Community Sexual Health Practitioner, Melbourne, Victoria, Australia

ABSTRACT

Background

Patients in sexual medicine often describe erotic distress through bodily language such as numbness, shutdown, tension, charge, or inability to stay present. Present models of desire, arousal, orgasm, pain, and trauma do not always provide a practical way to work with this pre-verbal embodied layer. This Innovation manuscript introduces erotic felt sense as a proposed clinical term for the bodily awareness of erotic aliveness, including self-expression, pleasure, agency, boundary, and relational readiness. The concept is translated as measurable domains rather than metaphysical claims: interoceptive awareness, autonomic regulation, muscular guarding, dissociation, and affect tolerance.

Objective

- To describe a clinically usable framework that integrates erotic embodiment, creative expression, and storytelling in holistic sexual-health care as an adjunct to standard medical and psychosexual treatment.
- To identify a next-step research pathway for a holistic mobile community qualitative project using storytelling as well as optional creative media.

Methods

- Narrative Innovation article drawing on peer-reviewed literature within embodied sexuality, interoception, trauma-related mind-body interventions, and storytelling in public health.
- Proposed three-part practice sequence: attunement to bodily signal, creative externalization, and narrative integration, making meaning.

Results

- The manuscript offers a new clinical language for a diverse range of patients who experience sexuality as difficult to name but strongly felt in the body.
- It reframes patient descriptions of "stored pain," "release," or "blocked energy" as clinically interpretable processes, including breath restriction, muscular holding, autonomic activation, sensory narrowing, and dissociative distance.
- It proposes that creative expression can help externalise difficult-to-verbalise sensations, and that storytelling can connect these sensations to safety, consent, shame, identity, and possibility.

Clinical Impact

- May improve sexual health history-taking in complex presentations.
- May help clinicians distinguish protective shutdown from low desire and support more embodied forms of consent, pacing, and referral.
- Creates a bridge between individual care and person-centred, community-based sexual-health research and knowledge translation.

Notable Comments

- This article does not present trial data.
- The next phase is a mobile, community-based qualitative project in Collingwood through Bridget's Bus, using safe storytelling spaces and optional digital/documentary methods to study sexuality, expression, and embodied meaning-making.

Conclusions: Erotic felt sense is proposed as a first description of a clinically relevant construct that may help sexual medicine address the holistic embodied and narrative dimensions of sexual wellbeing more precisely. The framework is feasible for a qualitative study and suitable for future mixed-methods evaluation.

***Corresponding author**

Bridget Scholes, Master of Sexology, Independent Sexologist and Community Sexual Health Practitioner, Melbourne, Victoria, Australia.

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Ethical Considerations for the Planned Mobile Qualitative Research Project

For a planned moving-site or mobile qualitative project, clinical support and research participation should be clearly separated so

that no participant feels obliged to participate in research to access care. Consent should be tiered across interview participation, use of creative artifacts, audio recording, photography, and use of documentary or public-facing stories, with separate consent for any identifiable dissemination. Participants should be able to choose anonymity, pseudonymity, or identifiable participation and should retain a defined right to withdraw material before final editing or publication deadlines. Because the project will involve sexuality, trauma histories, queer and neurodivergent communities, and potentially community settings outside conventional clinics, trauma-aware pacing, sensory accessibility, quiet-space options, and referral pathways for distress, violence, or acute mental-health need are essential. Data collection should be minimal, encrypted, and governed by clear limits around explicit content, while community governance should include queer and lived-experience input and culturally specific consultation wherever appropriate. If documentary methods are used, public screening or online circulation should occur only after a second release process and with participant review, support, and aftercare planning.

Erotic Felt Sense as a Clinical Innovation: Erotic Embodiment, Creative Expression, and Storytelling for Holistic Sexual Health

Erotic felt sense is introduced as a clinical term denoting bodily awareness of erotic aliveness, including pleasure, curiosity, agency, boundaries, and relational readiness. In sexual medicine, patients frequently report sensations of numbness or activation. Some clients' experience difficulty remaining present, identifying desire, or connecting with pleasure, even in the absence of structural disorder. Existing frameworks address arousal, desire, orgasm, pain, trauma, and relationships, yet they lack terminology for the pre-verbal, embodied, and meaning-laden aspects of sexuality. This innovation represents a paradigm shift by incorporating erotic embodiment, creative expression, and storytelling into sexual health care as adjuncts to standard treatment [1].

Erotic felt sense is conceptualised as a grounded, embodied capacity that extends beyond genital response. It encompasses the perception of erotic experience in the body before, during, and after meaning is assigned. This includes changes in breath and breath texture, muscular holding, warmth, movement, contraction, appetite, aversion, settling, and relational orientation. Patients may describe these experiences using terms such as "energy," "charge," "shutdown," or "release." Clinically, these subjective reports can be translated into observable and measurable domains, including interoceptive awareness, autonomic regulation, dissociation, motor inhibition, affect tolerance, and the capacity to remain present with sensation. This translation enables clinicians to honour patients' lived language while maintaining a medically interpretable framework [2,3].

This innovation is grounded in three interrelated observations. First, erotic life is embodied and rooted in physical experience; regular embodied practice can shift sexuality from an externally evaluated phenomenon to one that is internally sensed. Second, interoception, defined as the ability to sense internal bodily states, significantly influences sexual well-being. Recent research indicates that higher self-reported interoceptive awareness in women correlates with increased orgasm frequency and satisfaction, highlighting the clinical relevance of internal state awareness for sexual function. Third, breath- and body-based interventions are particularly pertinent when trauma, dissociation, or chronic overactivation restrict sexual expression. In trauma-related disorders, mindfulness-based and body-oriented interventions demonstrate small to moderate positive effects on symptoms and interoception. Enhancing contact with internal sensation may therefore expand sexual agency and pleasure [4,5].

The proposed practice model consists of three movements, intentionally designed to be conversational rather than strictly protocol-driven. The first movement involves attunement to bodily signals, where clinicians invite patients to notice the emergence of erotic charge, shutdown, tension, warmth, longing, fear, or pleasure within the body. Patients are encouraged to track subtle changes in breath, posture, and muscle tension while remaining within a tolerable range. The second movement, creative externalisation, provides alternative modes of expression when sensations are difficult to verbalise. Patients may draw, use colour, select metaphors, gesture, move, or describe experiences using images, textures, or sounds [6].

This approach is particularly beneficial when shame, neurodivergent communication styles, alexithymia, or trauma impede direct description. The third movement, narrative integration, encourages patients to connect bodily sensations with personal narratives, exploring questions such as: When has this aspect of self been expressed? When has it felt forbidden, unsafe, or invisible? What factors increase safety, erotic potential, or consent? In this model, narrative meaning organises physiological experience [7].

Creative expression serves as a clinical bridge rather than mere embellishment, particularly when trauma, marginalised stress, chronic shame, pain, or misunderstanding hinder cognitive expression of erotic experiences. Marginalised stress, in this context, refers to emotional strain resulting from exclusion or discrimination. Creative externalisation employs artistic forms or techniques to explore and communicate complex experiences. In public health, storytelling has revealed insights that standard approaches often overlook and has influenced knowledge, attitudes, and practices. Similarly, in sexual medicine, clinicians may utilise guided narrative structured storytelling processes, sometimes combined with creative externalisation, to help patients articulate experiences that standard history-taking may not capture. This approach also facilitates more individualised care planning [8-11].

The model is particularly relevant for patients whose sexuality is characterised by vigilance, defined as sustained alertness to potential threat or discomfort rather than exploration. This population includes survivors of sexual trauma, individuals with chronic pelvic pain, queer, culturally diverse, and gender-diverse patients experiencing social minority stress, and neurodivergent individuals. For neurodivergent patients, sensory processing differences can influence erotic comfort. The objective is not to intensify erotic response on demand, but to enhance patients' accuracy, safety, and autonomy in perceiving and expressing erotic information. In clinical practice, this increased clarity may help distinguish low desire from protective shutdown, a coping strategy in which desire is reduced. Patients may also identify contexts that support embodied consent, defined as genuine physical and emotional agreement, and recognise when further medical evaluation is warranted for issues such as pain, hormonal changes, medication effects, or pelvic floor dysfunction [12,13].

This framework is intended to complement, not replace, standard sexual medicine evaluation. Clinicians are still required to assess and refer patients presenting with pelvic pain, vulvovaginal symptoms, erectile dysfunction, pharmaceutical effects, endocrine changes, neurological illness, and relationship violence using conventional methods. The innovation provides a structured approach to addressing the bodily dimension between symptoms and narrative. For instance, patients may describe pain, fear, shame, or erotic possibility as being "stored" in the body. This model interprets such statements as clinically meaningful,

referencing phenomena such as breath restriction, muscular guarding, autonomic activation, dissociative distance, or sensory narrowing. Clinicians can address these domains through paced attention, movement, and narrative meaning-making, rather than relying solely on interpretation [14,15].

This innovation also provides a practical bridge between clinic and community research. The next step is a mobile qualitative project in community settings. This project will use guided storytelling alongside optional creative media to study how people describe erotic felt sense, how sexuality becomes speakable or unspeakable, and which conditions support liberation, safety, and expression. Documentary and digital story methods may be useful as knowledge-translation tools, but they should be treated as voluntary extensions of care and research rather than defaults. Erotic felt sense should therefore be understood as a proposed clinical construct and practice framework rather than a validated diagnostic category. Its value lies in helping sexual medicine speak more precisely to the embodied, relational, and storied dimensions of sexual health that patients already bring into the room [16,17].

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Authors Note
I am a queer sexologist, educator and creative writer, with a research master's degree in sexology and a community-based practice in Collingwood, Melbourne. In one-to-one/relational practice, education, and community work—including the development of Bridget's Bus mobile sexual-health, storytelling, and wellbeing project—I have worked with hundreds of clients throughout diverse intersections, including neurodivergent, queer, and culture and gender-diverse communities. My work is grounded in science-informed sexology and trauma-aware care while also drawing on holistic and contemplative modalities such as breathwork, meditation, movement, energy healing, and narrative meaning-making. Many clients describe the body as a place where pain, fear, desire, and possibility are held at the same time; where people use spiritual or energetic language, I translate this clinically into interoception, autonomic regulation, sensory processing and release, muscular holding, and somatic expression without erasing lived meaning. This manuscript grows out of that practice-based research trajectory along the next phase of the work: a holistic mobile community qualitative research project exploring how people sense, narrate, and express sexuality in everyday life.

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