

Integrative Sexual Wellness: A Collaborative Concierge Medicine Model for Optimizing Sexual Function and Enhancing Intimacy

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Abstract

Introduction: Sexual dissatisfaction and dysfunction remain widespread, impacting quality of life even among otherwise healthy individuals—calling for novel, integrative, medically grounded sexual wellness approaches. This feasibility study evaluated the Penetration Protocol—a trauma-informed psychosexual intervention integrating somatic education, cognitive reframing, and partner-based practice—to optimize sexual satisfaction, embodiment, and relational connection. **Methods:** Eighty-six participants (43 couples) enrolled in an eight-week online protocol combining 33 pre-recorded educational modules with weekly live virtual integration sessions. Feasibility outcomes included engagement, clarity, practicality, and perceived benefit. Secondary outcomes assessed changes in sexual satisfaction, communication, orgasmic function, emotional intimacy, penetration duration, and frequency of sexual activity using validated instruments (e.g., NSSS, FSFI-S, DSCS, TLS-15) alongside self-constructed measures. **Results:** High engagement (content engagement mean = 79.1%) and clarity (mean = 89.5%) were observed. Sexual satisfaction scores (NSSS) increased by 36.4% ($p < 0.001$), dyadic sexual communication improved by 15.5% ($p < 0.001$), and female orgasmic function (FSFI-S orgasm domain) significantly improved ($p < 0.001$). Emotional intimacy also increased (TLS intimacy subscale, $p = 0.006$). Exploratory measures revealed significant gains in sexual frequency ($p = 0.0012$), sexual duration ($p = 0.004$), penetration length ($p = 0.0023$), sexual confidence ($p < 0.00002$), and emo-

tional closeness after intercourse ($p < 0.001$). **Discussion:** Findings suggest the Penetration Protocol is a feasible, engaging, and effective intervention for enhancing sexual function, intimacy, and emotional connection. When paired with concierge regenerative medicine retreat-style protocols, this integrative model may further optimize sexual function, enhance intimacy, and potentiate neuroendocrine resilience, transpersonal growth, and sensual self-actualization. Further studies are warranted based on promising preliminary findings.

Keywords

Sexual Wellness, Psychosexual Therapy, Somatic Sex Education, Mind-Body Medicine, Entheogenic Medicine, Regenerative Medicine, Erotic Individuation, Orgasmic Function, Intimacy Optimization, Transpersonal Psychology, Self-Actualization, Naturopathic Interventions, Concierge Medicine, Cellular Regeneration

1. The Problem

Sexual dysfunction and dissatisfaction affect a significant proportion of men and women worldwide, impairing quality of life, relational harmony, and psychological well-being. While biological, psychological, and relational factors have long been recognized as contributors, emerging research highlights the profound influence of environmental toxicants—particularly endocrine-disrupting chemicals—on sexual and reproductive health. Beyond diagnosable dysfunctions, pervasive sexual dissatisfaction often remains unaddressed, yet profoundly impacts emotional vitality and relational satisfaction. Conventional interventions, though effective in mitigating symptoms, frequently neglect the embodied, relational, and regenerative dimensions essential for sustainable sexual wellness. In response, a paradigm shift is needed: from treating dysfunction as pathology to cultivating erotic vitality as a component of holistic well-being. Grounded in the principles of naturopathic medicine and structured by the Therapeutic Order, the Penetration Protocol offers a novel, integrative framework to optimize sexual function, intimacy, and self-actualization.

1.1. Prevalence and Contributing Factors in Sexual Dysfunction

Sexual dysfunction exerts a pervasive impact on human health, arising from the intricate interplay of vascular, neurological, endocrine, psychological, and sociocultural factors. Epidemiological studies report that approximately 31% of men experience erectile dysfunction (ED), with prevalence increasing with age [1]. Premature ejaculation (PE), affecting around 23% of men, remains the most commonly reported male sexual dysfunction and is frequently associated with anxiety and relational dissatisfaction [2]. Delayed ejaculation (DE), though less common, has been linked to serotonergic antidepressant use and psychological factors [3]. Hypoactive sexual desire disorder (HSDD) affects about 1.8% of men aged 16 -

44, with rates escalating in older age groups due to hormonal decline, chronic disease, and psychosocial stressors [4].

Among women, sexual dysfunctions are equally pervasive. Anorgasmia affects approximately 25% of women, with 10% reporting never having achieved orgasm [4]. Vaginal dryness, a hallmark of estrogen deficiency, affects 50% - 60% of postmenopausal women and significantly contributes to dyspareunia [5]. Dyspareunia itself affects up to 30% of women during vaginal intercourse and 72% during anal intercourse, often rooted in infections, endometriosis, trauma, or hormonal imbalances [4]. Hypoactive sexual desire disorder affects about 30% of women, reflecting a multifactorial interplay of emotional intimacy, psychological resilience, and endocrine status [6]. Conditions such as vaginismus—an involuntary contraction of pelvic floor muscles—affect up to 6.5% of women and are frequently trauma-linked. Female Sexual Arousal Disorder (FSAD), reported by approximately 20% of women, is often related to vascular insufficiency, autonomic dysfunction, and hormonal changes [6].

1.2. Environmental Contributions to Hormonal Decline and Sexual Dysfunction

Emerging evidence underscores the role of environmental toxicants in the erosion of reproductive vitality. Since the 1980s, male testosterone levels have declined at an estimated 1% annually [7], a trend corroborated by recent meta-analyses documenting a greater than 50% decrease in sperm counts between 1973 and 2018 [8] [9].

In women, rising rates of polycystic ovarian syndrome (PCOS), early menopause, anovulatory cycles, and endometriosis have been increasingly associated with exposure to endocrine-disrupting chemicals (EDCs) such as phthalates, bisphenol A (BPA), and per- and polyfluoroalkyl substances (PFAS) [10] [11]. These compounds disrupt the hypothalamic-pituitary-gonadal (HPG) axis by mimicking or antagonizing sex hormones, impairing reproductive function. For example, BPA interferes with estrogen receptor binding, while phthalates inhibit testosterone synthesis. PFAS exposure has been linked to delayed menarche, menstrual irregularities, and diminished ovarian reserve [12].

Volatile organic compounds (VOCs) emitted from common household items, including memory foam mattresses and synthetic furnishings, further exacerbate reproductive risk by disrupting sleep architecture and contributing to hormonal dysregulation—critical elements in maintaining libido and reproductive health [13] [14].

Collectively, the cumulative burden of environmental exposures contributes substantially to the global burden of sexual dysfunction, emphasizing the necessity of integrative diagnostic and therapeutic approaches that address ecological, biological, and relational dimensions.

1.3. Sexual Dissatisfaction Beyond Clinical Diagnosis

Beyond diagnosable dysfunctions, sexual dissatisfaction remains widespread and

under-addressed, despite its significant influence on emotional health and relational longevity. Large-scale surveys reveal that 43% of women and 31% of men report enduring sexual difficulties, including reduced arousal, diminished orgasmic capacity, or dissatisfaction with partnered intimacy [4] [15].

In long-term relationships, sexual dissatisfaction often stems not from dysfunction per se but from routinized, mechanical sexual scripts that prioritize relational stability over erotic vitality [16]. Research consistently links sexual satisfaction to psychological resilience, relational commitment, and general well-being [17] [18], while persistent dissatisfaction has been associated with increased depressive symptoms and relational dissolution [19].

Historical psychosexual interventions, such as Sensate Focus Therapy, pioneered by Masters and Johnson [20], effectively addressed performance anxiety through non-demand touch but often neglected the development of penetrative skill, orgasmic capacity, and embodied emotional intimacy [21] [22].

1.4. Expanding the Paradigm: From Dysfunction to Fulfillment

Recent advances in digital psychosexual education have broadened access to structured interventions capable of enhancing sexual function, arousal confidence, and intimacy [23] [24]. Cognitive-behavioral models adapted to online formats promote empowerment and self-directed sexual skill-building [25] [26].

However, sexual dissatisfaction and dysfunction often reflect multifaceted etiologies encompassing physiological, emotional, relational, and existential dimensions. Addressing these complexities requires integrated, trauma-informed approaches that cultivate embodied erotic intelligence, relational attunement, and regenerative vitality—principles central to the naturopathic medical model.

1.5. The Therapeutic Order: A Framework for Integrative Sexual Wellness

The demands of insurance-driven healthcare systems, where physicians allocate a median of just 18.9 minutes per patient encounter [27], are ill-suited for addressing the nuanced terrain of sexual health. Naturopathic medicine offers an alternative: the Therapeutic Order, a seven-tiered clinical hierarchy progressing from least to most invasive interventions [28]-[30].

The Therapeutic Order prioritizes (1) removal of obstacles to health; (2) stimulation of the self-healing response; (3) strengthening weakened systems; (4) correction of structural integrity; (5) restoration using natural substances; (6) judicious use of pharmacological agents; and (7) high-force interventions only when necessary [30].

1.6. Naturopathic Principles for Sexual Vitality

The philosophical foundation of naturopathic medicine—*Vis Medicatrix Naturae* (healing power of nature), *Tolle Causam* (identify and treat the cause), *Primum Non Nocere* (first, do no harm), *Docere* (doctor as teacher), *Preventare* (preven-

tion as the best cure), and *Tolle Totum* (treat the whole person)—provides a sophisticated, ethical compass for regenerative sexual health [31].

Applied to sexual vitality, these principles call for comprehensive diagnostics, trauma-informed relational healing, mind-body integration, and regenerative therapies such as pelvic rehabilitation, hormone balance, neuromodulation, and somatic psychosexual education. In the concierge model, liberated from conventional time constraints, these principles enable transformational healing processes that affirm erotic sovereignty, resilience, and whole-person flourishing.

2. The Methodologies

2.1. The Embodied Psychosexual Method (EPSM)

The Embodied Psychosexual Method (EPSM), formerly known as the Désilets Method (DM), is a transdisciplinary psychosexual framework developed by Dr. Saida Désilets in 2001. The method integrates somatic practices, breathwork, sexual reflexology, and transpersonal psychology into a structured system designed to support the reclamation of erotic agency, nervous system regulation, and sexual vitality [32].

The origins of EPSM are deeply personal and clinically significant. Following a near-death experience in 1994 due to a violent sexual assault, Dr. Désilets began to explore embodied methodologies that could restore health and intimacy after trauma. Drawing from Taoist sexual reflexology, the Five Element theory of Traditional Chinese Medicine (TCM), qigong, dance therapy, and mindfulness meditation, she synthesized a set of embodied practices and psychosexual frameworks that became the foundation of EPSM. Additional influences include expressive arts therapy, Neurosculpting principles for neuroplastic re-patterning, and yoni journaling—a practice involving writing from the perspective of one’s genitals to access subconscious emotional material.

A key component of EPSM is the Psychosexual Map—a sexual, reflexology-based visualization technique linking zones of the genitals to specific emotional states, integrated with the Taoist practice of the Six Healing Sounds [33]. For example, the kidney region, associated with fear, is activated through breath, sound (“choooo”), and visualization of color (blue on inhale, black on exhale) to process unresolved fear and cultivate calm. This structured process supports the transformation of difficult emotions such as grief, anger, or shame into states of courage, compassion, or joy using somatic anchoring. Color therapy, breathwork, and guided visualization are used in tandem to engage the vagus nerve and promote neurophysiological coherence.

Complementary practices include the Heart-Genital Meditation, which involves synchronized breath and hand placement over the heart and pelvic region. Through vocalization (“hahhhh”), patients cultivate interoceptive awareness and connection between emotional and erotic centers. This practice facilitates the state of “relaxed arousal”—a parasympathetically dominant condition in which arousal is experienced without anxiety or tension, laying the foundation for self-trust and

embodied intimacy.

EPSM also incorporates the structured use of a jade egg (yoni egg) to build proprioceptive and sensorial awareness of the vagina. Exercises with the jade egg are designed to restore pelvic tone, increase vaginal sensitivity, develop vaginal dexterity, and rebuild consent-based erotic engagement. These practices are especially beneficial for clients experiencing pelvic trauma, menopausal vaginal atrophy, low libido, or chronic genital numbness.

In 2005, Dr. Désilets contributed her psychosexual mapping techniques and reclining adaptations of traditionally seated Taoist practices to *The Multi-Orgasmic Woman*, making them more accessible to women across life stages and physical abilities [34]. By 2008, she completed a dissertation exploring early pilot data, revealing that participants who engaged with her frameworks—whether through embodied practice or reflective inquiry—reported sustained improvements in sexual wellbeing [35]. Remarkably, vulvar tissue changes were noted in an unpublished study conducted by gynecologist Dr. Deborah Wickman. In this study, women exposed to EPSM showed measurable physiological changes in the ostia of the Skene's glands, as verified through pre- and post-intervention pelvic exams. In contrast, a control group of 300 women not exposed to EPSM showed no such changes, suggesting that embodied psychosexual methods may influence genital physiology [36].

EPSM has been disseminated through trainings to physicians, psychotherapists, trauma specialists, sex educators, and bodyworkers. Since 2013, the method has been formally included in the *Connection Anthology: Human Sexuality and Intimate Relationships from an Integral, Transpersonal, and Somatic (Sexological) Perspective* [37]. It is trauma-informed, developmentally sensitive, and designed to be inclusive of all ages, body types, sexual orientations, and cultural backgrounds. Recognizing that conventional trauma-informed models often prioritize stabilization over flourishing, EPSM advances into a trauma-transcendent framework. This approach supports not only the regulation of trauma responses but also the cultivation of erotic vitality, relational depth, and embodied thriving. In alignment with emerging transpersonal perspectives [38], trauma-transcendence reflects a shift from symptom management to expanded emotional integration, resilience, and transformational growth.

At its core, EPSM does not pathologize sexuality but rather reframes erotic embodiment as a vital dimension of whole-person health. It offers a comprehensive and compassionate roadmap for individuals seeking to move beyond sexual trauma, enhance their relationship to pleasure, and reclaim agency in their erotic lives through the cultivation of emotional literacy.

2.2. The Aaron Michael Enactive Sexual Method (ESM)

The Aaron Michael Enactive Sexual Method (ESM), is a multidisciplinary, psychosomatic framework designed to address sexual dysfunction, enhance pleasure, and deepen emotional and relational intimacy through a trauma-informed, em-

bodied approach [39]. Developed by Aaron Michael, MA, ESM emerged in clinical practice to meet the unmet needs of clients who, despite receiving psychological diagnoses or physical treatments, continued to experience sexual dissatisfaction, pain, numbness, or emotional disconnection in intimate relationships.

Clients often reported that while prior therapeutic interventions helped them intellectually understand their triggers, symptoms, or trauma histories, they remained trapped in repeating cycles of dysfunction—ranging from avoidance and anxiety to shame, boredom, hyper-arousal/hypo-arousal, pain, and numbness. These patterns often persisted physiologically, undermining identity formation, relational trust, and self-esteem. ESM was developed as a response to these limitations, providing tools not only for overcoming dysfunction but also for optimizing embodied sexual expression, erotic confidence, and mutual pleasure.

Foundational Theoretical Framework

ESM is grounded in Gestalt psychology and the enactive approach to cognitive science. Building upon the early Gestalt work of Wertheimer [40], Koffka [41], Köhler [42], and Ellis [43], which emphasized perception as an organized whole rather than a sum of disconnected parts, ESM views sexual experiences as relational, embodied systems of meaning. This foundation is extended through the enactivist framework of Varela, Thompson, and Rosch [44] [45], which conceptualizes cognition as arising through the dynamic interplay between body, environment, and interpersonal co-regulation. Further theoretical grounding comes from enactive participatory sense-making, as articulated by De Jaegher, Di Paolo, Rohde, and Gallagher [46]–[48]. This lens asserts that meaning emerges through embodied interaction rather than isolated internal processing. ESM operationalizes this through practices that enable clients to co-create erotic experiences with their partners, re-patterning arousal, communication, and pleasure through live, embodied feedback loops.

Core Sub-Methods of the Enactive Sexual Method (ESM)

The Enactive Sexual Method (ESM) consists of five interrelated sub-methodologies that work together to recondition dysfunctional patterns and foster optimal sexual, emotional, and relational function. Each sub-method addresses a distinct but interconnected domain—foundational intimacy, relational attachment, bodily communication, psychological arousal, and biomechanical coordination—forming a cohesive system for somatic learning, emotional integration, erotic individuation, and relational resilience:

Embodied Love™

Embodied Love™ [49] provides the foundational framework for all ESM practices. It offers a communication model rooted in four core relational competencies—truth, responsibility, trust, and celebration—applied across relational goals, daily interactions, and intimate experiences. Through the practice of Embodied Love, participants learn to cultivate intimacy not simply as emotional closeness, but as a dynamic, lived experience of shared values and embodied connection. This framework establishes the emotional and energetic foundation from which

the other sub-methods grow, ensuring that somatic re-patterning is anchored in authentic relational depth.

Relational Re-Patterning

Building on this base, Relational Re-patterning focuses on transforming attachment dynamics through somatic and relational exercises. Participants are guided to replace ingrained patterns of avoidance, anxiety, or disorganization with secure, pleasure-centered bonds. This process cultivates new relational templates based on safety, flexibility, and trust, restoring the capacity for healthy, resilient intimacy.

Attuned Engagement

Attuned Engagement (specific practices extracted from the comprehensive system trademarked as Embodied Consent™) [50] refines the way partners navigate consent and connection by extending traditional verbal consent models into fully embodied practices. Through structured training in expressing, receiving, and adjusting consent via somatic cues, movement, and real-time feedback, participants develop nonverbal fluency. These dynamic communication skills reduce misunderstandings, foster co-created pleasure, and build trust as a living, responsive system throughout both sexual and everyday interactions. Attuned engagement expands traditional models of verbal consent into a fully embodied, relational practice. It trains individuals and couples to express, interpret, and attune to consent through somatic cues, movement, and sensory feedback.

Mindfulness & Somatic Awareness:

Participants are guided through exercises that enhance bodily self-expression and partner attunement. Movements such as arm and leg positioning are explored as expressions of “yes”, “no”, or “maybe”, cultivating increased awareness and nonverbal communication fluency. These practices reduce patterns of fawning, freezing, or dissociation in everyday, non-sexual interactions for all ages, but they also translate into intimacy.

Dynamic Intimate Communication:

Attuned engagement offers a lexicon of physical signals—pushes, pulls, stillness—that couples can use during sexual engagement to calibrate depth, angle, rhythm, and emotional intensity. This dynamic signaling system reduces misunderstandings, builds trust, and supports responsive rather than performative sexual experiences.

Erotic Mind Mapping

Erotic Mind Mapping addresses the mental and emotional dimensions of arousal. It guides individuals in exploring, expanding, and integrating diverse sources of erotic inspiration—linking conscious fantasy, unconscious longing, and embodied experiences into a holistic, flexible erotic ecosystem. By reorganizing internal arousal templates, participants reclaim sovereignty over their erotic identity and expand their capacity for spontaneous, emotionally connected intimacy.

Pelvic Synchronization

Pelvic Synchronization (extracted techniques from the comprehensive system trademarked as Suction Sex™ [51]) integrates breathwork, pelvic floor engagement, and hip movement into a dynamic system designed to optimize sexual stamina, deepen arousal, and regulate autonomic nervous system function. By training the body to cycle rhythmically between sympathetic and parasympathetic states during intimacy, Pelvic Synchronization enhances vagal tone, distributes genital pleasure more evenly, bridges the orgasm gap, and extends male endurance. This method supports a model of non-linear, co-regulated pleasure that contrasts with conventional friction-driven sexual performance patterns.

Pelvic Synchronization is the biomechanical and neurological centerpiece of ESM. It introduces a synergistic method of breath, pelvic floor activation, and hip movement to regulate the autonomic nervous system and optimize arousal. Unlike conventional friction-based sexual practices that drive the body into a purely sympathetic climax and refractory period, Pelvic Synchronization supports cyclical transitions between parasympathetic and sympathetic states, enabling prolonged pleasure and enhanced resilience.

1. Physiological Impact

Through breath-led pelvic expansion and dynamic thrusting, participants alternate between states of high arousal and deep relaxation. This cyclical modulation has been shown to stimulate vagal tone, improve erectile sustainability, and support female engorgement—activating the pudendal, hypogastric, pelvic, and vagus nerves for more distributed pleasure across the genital network [52]-[54].

2. Anatomical Integration

The method of Pelvic Synchronization draws attention to full-genital arousal as a system of pleasure, rather than focusing exclusively on clitoral or penile friction. Instructional animations and anatomical mapping support users in engorging and pleasuring erogenous zones for prolonged, non-linear stimulation, increasing orgasm duration and intensity, bridging the orgasm gap, and extending male lasting time from 4 - 5 minutes to 12 - 15 minutes.

3. Biomechanical Coordination

Pelvic Synchronization introduces the dynamic roles of *active-receiver* and *adaptive-giver*. Those being penetrated are taught to use pelvic floor engagement and hand positioning to guide penetration in, while those penetrating learn to attune to anatomical feedback, pacing, and depth. This bidirectional model reduces performance anxiety and fosters consent-led, co-created pleasure.

Clinical Utility and Integration

Together, these five sub-methods form a comprehensive, dynamic system for psychosexual re-patterning. ESM complements cognitive, behavioral, and somatic therapeutic approaches by addressing what many frameworks overlook: the critical need for real-time, relational, and embodied transformation. Rather than pathologizing dysfunction, ESM reframes sexual and relational challenges as disruptions in adaptive coordination between self, body, and other. Through breath-led movement, structured communication practices, and relational attunement,

participants rewire their erotic and emotional templates into sustainable systems of pleasure, intimacy, and resilience.

The Enactive Sexual Method ultimately offers a complete biopsychosocial model for sexual function, intimacy, and relational growth. Its tools are actionable, its effects multidimensional, and its aim transformative: to move individuals and couples beyond coping and survival into embodied thriving and erotic individuation.

ESM complements existing therapeutic modalities such as cognitive behavioral therapy (CBT), sensate focus, and narrative therapy by addressing what those systems often overlook: the need for real-time, embodied, and relational re-patterning. ESM does not pathologize dysfunction but instead frames it as a disruption in the adaptive coordination between self, body, and other. Through intentional movement, structured breath, somatic communication, and guided relational exercises, clients rewire their sexual experiences as dynamic systems of pleasure, presence, and consent.

The Enactive Sexual Method culminates in its application as a structured, integrative modality that positions sexual function and intimacy as a coordinated biopsychosocial process. Its tools are actionable, its effects multidimensional, and its aim transformative: to move individuals and couples from disembodied coping into resilient, pleasurable, and self-aware connection.

2.3. The Penetration Protocol: A Synthesis of Désilets' EPSM and Aaron Michael's ESM

The Penetration Protocol is a trauma-informed, somatic sex therapy model developed through the integration of the Embodied Psychosexual Method (EPSM) and the Enactive Sexual Method (ESM). Designed to enhance penetrative sexual function, pleasure, and intimacy, the protocol addresses both physiological and psychological barriers to fulfilling sexual experiences. It is applicable across diverse populations, regardless of age, body type, gender identity, or relationship structure, and aims to support an integrative experience of desire, arousal, orgasm, emotional regulation, and healthy relational dynamics.

Originally developed to resolve common sexual concerns such as premature ejaculation, anorgasmia, pain during intercourse, penetration anxiety, and pelvic floor dysfunction, the Penetration Protocol incorporates a range of embodied practices, including breathwork, vocalization, touch, movement, pelvic coordination, and pleasure-based anatomy. Psychological components are also central, with attention given to emotional blocks (e.g., shame, anxiety, boredom) and relational dynamics such as insecure attachment or conflict avoidance. The goal is not merely functional restoration but erotic individuation—where clients experience increased agency, self-awareness, and relational integrity in their sexual lives.

The origins of the Penetration Protocol can be traced to the distinct but complementary trajectories of its two co-creators. Since 2001, Dr. Saida Désilets has delivered her EPSM in over 16 countries through group sessions, individual work, and more than 10 online courses. In 2012, Aaron Michael began developing and

refining his ESM through bespoke private sessions and group classes in Europe, Africa, Central and North America. By 2019, Dr. Désilets reviewed the ESM's structure for relevance to her own work and began a collaborative synthesis. Together, they co-authored material for a UK-based sexual wellness app serving hundreds of thousands of users. This collaboration evolved into a comprehensive psychosexual system integrating the enactive, relational, and embodied principles of both methods.

By 2021, the team launched training programs for men, followed in 2022 by dedicated programs for women and couples, as well as co-ed in-person workshops. Their clinical work expanded to address a range of case-specific concerns, including erectile dysfunction, dyspareunia, dysmenorrhea, and menopausal symptoms. In 2023, they authored a penetration-focused sexual wellness protocol, from previous work, for a U.S.-based bioscience company and, in 2024, launched an IRB-approved feasibility study conducted in collaboration with researchers from Imperial College London to evaluate their protocol's clinical utility.

The Penetration Protocol builds on the foundational contributions of Sensate Therapy, originally developed by Masters and Johnson [55]. While Sensate Therapy emphasized non-demand, non-genital touch to reduce performance anxiety and enhance emotional presence, it did not directly address the biomechanical, anatomical, or trauma-specific challenges of penetrative sex [56] [57]. The Penetration Protocol extends this tradition by offering a structured, experiential method that explicitly reintroduces penetration within a somatically attuned, consensual, and therapeutic context.

Key differentiators of the Penetration Protocol included aspects of the following:

- **Engorgement and pelvic readiness training:** Techniques from ESM emphasizing education on vascular and muscular arousal responses to optimize comfort and sensitivity during penetration.
- **Pelvic biomechanics:** ESM training in suction-based movement, reverse-thrust techniques, and partner-supported hip coordination to improve sexual pacing and responsiveness.
- **Genital mapping and sensation awareness:** Techniques from ESM are used to awaken desensitized or armored tissue and facilitate embodied awareness.
- **Attuned engagement:** A signature element of ESM that replaces static verbal consent with real-time, dynamic somatic communication using breath, eye contact, and movement to signal boundaries, desires, and pacing. Pelvic Synchronization, as developed by Aaron Michael, is a somatic method that integrates breathwork, pelvic expansion, and gluteal engagement to activate parasympathetic arousal, enhance proprioceptive awareness, and support co-regulated sexual rhythm. The technique is designed to prolong pleasurable states, reduce premature climax, and foster embodied responsiveness and mutual attunement. In the context of the current intervention, only foundational elements of Pelvic Synchronization were included, as the Penetration Protocol

was intended for broad applicability across diverse partner dynamics and was implemented over a limited eight-week period with single weekly sessions. Core components drawn from Pelvic Synchronization—which had already been developed and tested prior to the creation of the Penetration Protocol—included active receiver and adaptive giver dynamics, engorgement and pelvic readiness training, pelvic and hip movement biomechanics, genital mapping, sensory differentiation, and pleasure-centered anatomical education.

The active receiver and adaptive giver framework, in particular, was central to Pelvic Synchronization well before the protocol’s formalization. This model was developed to challenge static gender norms and conventional penetrative scripts by empowering receivers to guide the pace and depth of penetration through pelvic musculature and embodied signaling, while givers are trained to attune and respond with anatomical and emotional sensitivity. This fluid, co-regulatory exchange reduces performance pressure, mitigates penetration anxiety, and supports neuro-physiological synchronization. It is important to note that Pelvic Synchronization encompasses a broader range of applications—including oral, energetic, and full-body erotic practices—which were beyond the scope of this feasibility study.

A comparative summary highlights how the Penetration Protocol builds upon Sensate Therapy:

Sensate Therapy	Penetration Protocol
Focus on non-demand touch	Includes full arousal-to-entry training
Reduces performance anxiety	Transforms penetration anxiety
Improves intimacy and connection	Trains pelvic floor, suction, and hip movement
Addresses penetration experientially, without providing instructions “how” to penetrate	Emphasizes attuned engagement and feedback; provides instructions on “how” to penetrates
Does not address penetration-specific challenges	Aims for erotic individuation and optimal sexual health

Through its multidimensional design, the Penetration Protocol reframes penetrative sex not as a goal-oriented act but as a co-regulated, sensual journey. It supports not only functional outcomes but emotional intimacy, erotic exploration, and spiritual integration.

Together, the EPSM and ESM components of the Penetration Protocol provide a comprehensive system for transforming sexual dysfunction into empowered, embodied experience. The method represents an emerging standard for integrative sex therapy that bridges the physiological, psychological, and transpersonal dimensions of human intimacy.

3. Methods

3.1. Study Design

This study employed a hybrid, mixed-methods design to evaluate the feasibility

and effectiveness of the Penetration Protocol, a structured psychosexual protocol designed to enhance penetrative sexual fulfillment. The intervention combined self-guided online modules with weekly live virtual sessions, and was implemented over an eight-week period. The study integrated quantitative analysis of validated outcome measures and self-constructed weekly Ecological Momentary Assessments (EMA) to capture dynamic, real-time changes in sexual satisfaction, functioning, and intimacy.

3.2. Ethical Approval

The study received IRB approval from the Quietmind Foundation (IRB #231025). The Quietmind Foundation is based in Elkins Park, Pennsylvania, USA. It is a nonprofit organization integrating neuroscience, psychology, and contemplative practices to support mental health and cognitive rehabilitation. The foundation also operates an Institutional Review Board (IRB) registered with the U.S. Department of Health and Human Services (HHS).

Informed consent was obtained electronically from all participants, who were fully briefed on the voluntary nature of their participation and their right to withdraw at any time without consequence. Confidentiality was maintained through encrypted data collection and storage procedures. Due to the intimate and potentially triggering nature of psychosexual content, the study followed trauma-informed guidelines. Facilitators were trained to recognize distress, establish safety protocols, and offer referrals for additional support when necessary.

The intervention was positioned as an experiential education and embodiment-based program, not a substitute for medical or psychiatric care. Participants already receiving psychotherapy were advised to integrate learnings collaboratively with their existing providers.

3.3. Eligibility Criteria

To ensure the integrity of study outcomes and minimize potential confounding variables, participants were screened using a rigorous set of exclusion criteria. Individuals with a history of severe mental illness—particularly those recently hospitalized for suicidality or reporting active suicidal ideation—were excluded due to the protocol's emotionally evocative nature and its non-clinical format. Participants with current or past substance use disorders were also excluded, given the potential for mood instability and impaired self-regulation that could interfere with protocol adherence. Other exclusion criteria included current pregnancy (due to physiological and hormonal changes affecting sexual function and safety), and relationship instability—such as being newly partnered or actively navigating a separation or divorce—which could introduce volatility into the dyadic dynamics assessed. Additionally, individuals taking medications known to significantly alter sexual function (e.g., serotonergic antidepressants, antipsychotics, beta-blockers, chemotherapy agents) were excluded to reduce pharmacological confounding of sexual health outcomes. The screening process began with a compre-

hensive pre-screening survey administered via Qualtrics, followed by individual video interviews with each partner conducted by the research team. These interviews allowed for clarification of eligibility, offered an opportunity for informed consent, and ensured a private, nonjudgmental space for discussing sensitive topics such as relational safety, trauma history, or emotional readiness for the protocol.

3.4. Inclusion Criteria

To be included in the study, participants were required to meet specific relational, psychological, and logistical conditions to ensure consistency, safety, and relevance to the protocol goals. Eligible individuals were adults aged 18 or older, currently in a romantic and sexually active relationship of at least six months' duration, to ensure sufficient relational stability for observing longitudinal change. Participants had to possess a working knowledge of English and consistent access to the internet and a private device capable of accessing the online learning platform and Zoom video conferencing. Both partners were expected to express genuine interest in improving their intimate connection and sexual fulfillment through structured, self-directed work. A baseline willingness to engage in weekly practices—such as journaling, mindful touch, and communication exercises—was required. Importantly, participants had to demonstrate emotional readiness and relational safety, as determined during a structured intake interview with the research team. This dual-level screening process ensured that participants had both the capacity and commitment to fully engage with the intervention over the eight-week duration.

3.5. Study Design and Procedure

This study employed a prospective, single-arm feasibility design to evaluate the Aaron Michael ESM and Désilets EPSM—a psychosexual intervention aimed at enhancing penetrative sexual satisfaction within committed relationships. The intervention was delivered in a hybrid format over an eight-week period, combining asynchronous learning with synchronous community engagement and support.

Participants engaged in a structured protocol that included 33 pre-recorded video modules, each approximately 5 - 10 minutes in length. These modules progressively introduced elements of the *Penetration Protocol*, a phased curriculum addressing psychological, physiological, and relational aspects of penetrative intimacy. Educational content was hosted on a secure online platform, allowing participants to engage with the material flexibly and privately.

In addition to the asynchronous material, participants attended weekly live group Zoom sessions facilitated by the protocol creators. These sessions were designed as moderated Q&A forums rather than therapeutic groups, providing real-time clarification, peer encouragement, and embodied integration of the week's themes. Participants could submit questions anonymously in advance, creating a safe environment for discussing sensitive topics.

The protocol incorporated a series of guided somatic and relational exercises,

including pelvic floor breathing, genital-heart meditation, hip coordination drills, and partner-based communication practices. These exercises were designed to be practiced three to four times per week, either solo or with a partner, and served to build awareness, erotic resilience, and embodied connection.

All participants completed a baseline battery of validated psychometric measures prior to starting the program, and a post-intervention battery upon completion of the eight weeks. Additionally, participants were invited to complete brief weekly self-report surveys using visual analogue scales (VAS) to track engagement, satisfaction, and perceived benefits in real time. These weekly assessments evaluated feasibility-related domains such as clarity, relevance, practicality, and protocol adherence, as well as self-perceived changes in sexual confidence, communication, and intimacy.

This blended model of self-paced content, live group facilitation, and multidimensional outcome tracking was designed to mirror a real-world implementation of an integrative sexual wellness program, while also supporting ecological validity and participant autonomy.

3.6. Penetration Protocol Overview: Intervention Content and Delivery

The combined EPSM and ESM is delivered as a progressive, five-phase online psychosexual curriculum designed to optimize penetrative intimacy through embodied education, trauma-informed skill-building, and erotic self-awareness. The curriculum spans approximately eight weeks in its core format but is structured to accommodate a longer, self-paced integration process in real-world application. Participants accessed 33 pre-recorded video lessons, averaging 5 - 10 minutes each, and practiced complementary guided exercises to reinforce experiential learning. The video lessons were adapted from the Lessons 1 - 33 in written format (**Appendix A**). The protocol content is summarized below:

Phase 1, Weeks 1 - 2 (Lessons 1 - 15): Erotic Individuation and Sexual Sovereignty: This foundational phase focused on establishing psychological readiness for deepened intimacy. Participants were introduced to the core mindset of *erotic individuation*—reclaiming agency over one's sexual identity—and *sexual sovereignty*.

- 1) Setting the Foundation (Lessons 1 - 3)
- 2) Addressing Psychosexual Blocks to Arousal and Penetration (Lessons 4 - 5)
- 3) Addressing Situational Blocks (Lesson 6)
- 4) Countering Self-Sabotage (Lessons 7 - 12)
- 5) Awakening Penetration Arousal (Lessons 13 - 15)

Phase 2, Weeks 3 - 4 (Lessons 16 - 24): Pre-Penetration Engorgement & Arousal Preparation: Participants developed somatic and relational practices to support full-body arousal and readiness for penetration.

- 1) Pelvic Floor Breathing Techniques (Lessons 16 - 18)
- 2) Heart-Genital Meditation for Erotic Coherence (Lesson 19)
- 3) Embodied Consent and Nervous System Co-Regulation (Lessons 20 - 22)

4) Hip Coordination and Movement Foundations (Lessons 23 - 24)

5) A Brief Integration Week

Phase 3, Weeks 4 - 5 (Lessons 25 - 28): Entry Preparation and Penetrative Skill: This phase focused on the mechanics of conscious penetration, including positioning, body weight distribution, and pressure awareness.

1) Pelvic Floor Mechanics for Entry (Lessons 25 - 26)

2) Managing Weight and Pressure for Entry (Lessons 27 - 28)

3) Brief Integration Period

Phase 4, Weeks 5 - 6 (Lessons 29 - 33): Erotic Movement and Communication: This stage introduced subtle and conscious movement during penetration, emphasizing mutual responsiveness, erotic language, and internal mapping.

1) Thrust and Reverse Thrust Techniques

2) Signaling for What You Want (non-verbal and verbal)

3) Erotic Mapping and Responsive Adjustment

4) Brief Integration Period

Phase 5 (Weeks 7 - 8+): Protocol Integration and Sustainable Intimacy

The final phase focused on the long-term integration of skills developed throughout the program. Rather than presenting new lessons, this phase offered reflective and embodied practices designed to deepen connection, sustain pleasure, and encourage ongoing exploration beyond the formal protocol. These integrative suggestions supported participants in making this style of intimacy a natural, plausible part of their daily lives—anchoring pleasure, presence, and partnership into sustainable, lived experience:

1) Identifying and Addressing Ongoing Blocks to Great Sex

2) Anchoring Intimacy and Erotic Communication in Daily Life

Note: While the intervention was structured for eight weeks in this study, the protocol is intentionally dynamic and non-linear. Participants are encouraged to progress at their own pace, revisit earlier lessons as needed, and allow space for emotional processing or relational repair if trauma responses or barriers emerge.

This phased design provided both structure and flexibility, empowering participants to cultivate erotic awareness, deepen partnered intimacy, and reclaim agency in penetrative sexual experiences. A list of the Lessons 1-33 that the videos are based on is provided in **Appendix A**.

4. Outcome Measures

4.1. Primary Outcome: Feasibility and Engagement

Feasibility and engagement were assessed weekly throughout the 8-week protocol using a brief online survey distributed via email. Participants completed self-report evaluations using visual analogue scales (VAS) ranging from 0 to 100, covering key aspects of protocol usability, content relevance, and satisfaction. These surveys were designed to evaluate both the delivery format (pre-recorded platform and live Zoom sessions) and the perceived value of the content delivered each week. The following seven domains were measured:

- 1) Relevance—Perceived personal and relational applicability of the content delivered that week.
- 2) Perceived Protocol Benefit—Subjective impression of how much the weekly material contributed to participants' sexual or relational development.
- 3) Clarity—Ease of understanding and digesting the lessons, practices, and instructions provided.
- 4) Content Engagement—Degree of attentiveness, interest, and active interaction with the week's materials.
- 5) Practice Engagement—Frequency and consistency with which participants engaged in the prescribed self-directed or partnered exercises.
- 6) Zoom Satisfaction—Satisfaction with the weekly live sessions in terms of facilitation, relevance, and sense of support or connection.
- 7) Practicality—Perceived ease of integrating the tools and teachings into daily life or intimate partnership.

Survey participation was voluntary, and participants were encouraged to complete surveys within seven days of each week's lesson. This multidimensional weekly assessment model provided a comprehensive view of the feasibility, user experience, and behavioral uptake of the intervention in real time.

4.2. Secondary Outcomes: Sexual Well-Being and Functioning

Secondary outcomes were assessed using a combination of validated psychometric instruments, weekly ecological momentary assessments (EMA), and baseline-to-endpoint self-constructed items. This multi-modal strategy enabled the study to capture both clinically validated endpoints and nuanced shifts in lived psychosexual experience across the 8-week protocol.

4.3. Validated Pre/Post Measures

Participants completed the following validated scales at baseline and post-intervention:

- 1) New Sexual Satisfaction Scale (NSSS): A 20-item instrument with subscales for Personal (ego-centered) and partner-centered satisfaction. Higher scores indicate greater sexual satisfaction [58].
- 2) Dyadic Sexual Communication Scale (DSCS): A 6-item scale assessing the ease and quality of communication around sexual needs and preferences [59].
- 3) Triangular Love Scale (TLS-15): A 15-item short form measuring intimacy, passion, and commitment in romantic partnerships [60].
- 4) International Index of Erectile Function (IIEF-5): A brief 5-item tool assessing erectile performance and confidence in men [61].
- 5) Female Sexual Function Index (FSFI-S): A 6-item validated scale measuring female sexual functioning across domains of desire, arousal, orgasm, satisfaction, and pain [62].
- 6) Inclusion of Other in Self Scale (IOS): A single-item pictorial measure of perceived closeness with one's partner [63].

7) Experiences in Close Relationships—Short Form (ECR-S): A 12-item scale assessing adult attachment anxiety and avoidance [64].

These validated instruments allowed the study to assess sexual satisfaction, communication, function, intimacy, and attachment across both individual and relational dimensions.

4.4. Weekly Sexual Well-Being Assessments (Ecological Momentary Assessment)

To capture dynamic changes during the protocol, participants were invited to complete brief weekly self-report surveys using a combination of visual analogue scales (VAS) and Likert-type questions. The following domains were assessed:

- 1) Sexual enjoyment (“How much do you enjoy sex during the act itself?”)
- 2) Sexual satisfaction (“After you have sex, how satisfied are you?”)
- 3) Emotional closeness (“After having sex, how would you rank your sense of emotional closeness with your partner?”)
- 4) Sex drive (“Compared to last week, how would you rank your sex drive this week toward your partner?”)
- 5) Sexual confidence (“Compared to last week, how would you rate your confidence in yourself as a sexual partner?”)
- 6) Sexual communication (“How easily were you able to communicate about your sexual fantasies and needs with your partner this week?”)

These weekly metrics enabled moment-to-moment tracking of perceived sexual well-being and were analyzed using linear mixed-effects models to account for non-normal distribution and time-based variance.

4.5. Self-Constructed Baseline and Endpoint Items

In addition to validated scales, participants completed exploratory measures at baseline and end-of-program that included these ten items in accordance with a Likert scale (see **Appendix B**):

- 1) Sexual Frequency: Assesses how often partnered sexual activity occurs.
- 2) Sexual Duration: Measures the average length of sexual activity.
- 3) Penetration Length: Evaluates the typical duration of penetrative intercourse.
- 4) Sexual Novelty: Assesses perceived routine versus variety in sexual experiences.
- 5) Sexual Shame: Measures internal barriers to sexual enjoyment due to shame.
- 6) Sexual Confidence: Assesses self-perceived competence and confidence as a sexual partner.
- 7) Sexual Satisfaction: Captures overall fulfillment with one’s current sexual life.
- 8) Intimacy: Evaluates emotional connection experienced during sex.
- 9) Closeness Before Sex: Assesses emotional intimacy with partner prior to sexual activity.
- 10) Closeness After Sex: Assesses emotional intimacy with partner following sexual activity.

These items allowed for a more holistic understanding of the participants' relational and sexual transformation beyond what is captured in standardized validated metric alone. The combination of validated scales, weekly EMAs, and custom measures provides strong support for both internal validity and ecological resonance with real-world intimate experiences.

5. Results

5.1. Participant Recruitment, Eligibility, and Retention

A total of 1015 individuals expressed interest in the Penetration Protocol. Prospective participants underwent a three-stage eligibility process: (1) completion of a screening questionnaire, (2) confirmation of committed, sexually active partnership, and (3) a video interview assessing relational stability and willingness to engage in psychosexual somatic practices. Inclusion criteria required participants to be adults (age 18+), fluent in English, in a committed romantic/sexual relationship for at least six months, and experiencing a desire to enhance sexual fulfillment. Couples had to be open to practicing new intimacy exercises, attending live Zoom sessions, and completing weekly assessments. Exclusion criteria included active trauma symptoms, untreated sexual dysfunction disorders, current substance abuse, or unresolved relational conflict that would preclude safe participation. **Figure 1** provides the Study Design Flow Diagram, displayed in accordance with CONSORT (Consolidated Standards of Reporting Trials) guidelines.

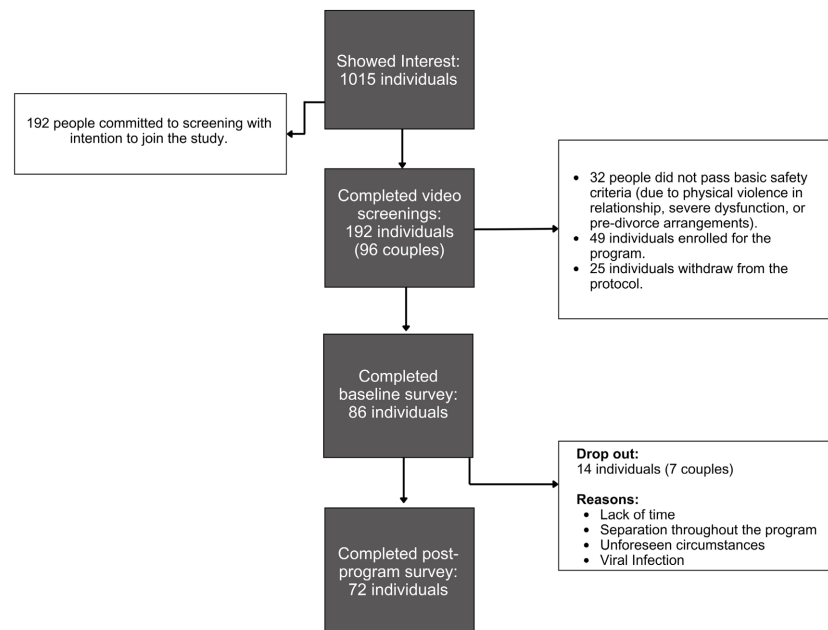


Figure 1. Study design flow diagram.

Figure 1 CONSORT-style flow diagram illustrating participant enrollment, allocation, intervention engagement, and follow-up in the feasibility study of the Penetration Protocol (N = 86 participants; 43 couples).

After applying these criteria, 86 individuals (43 couples) were enrolled, with a nearly even gender distribution: 52.3% identified as female and 47.7% as male. The majority were highly educated, with 69.7% holding a bachelor's degree or higher. An additional 15.1% had some college or a high school diploma, while 11.6% held professional or technical degrees, and only 1.2% had less than a high school education. In terms of ethnicity, the sample was predominantly White/Caucasian (83.7%), followed by Hispanic/Latino (7.0%) and other or mixed ethnic backgrounds (9.3%).

Employment status showed that 47.7% were employed full-time, 27.9% were self-employed, and the remaining 24.4% included part-time workers, retirees, homemakers, and students. Socioeconomic status was reported as above average by 51.2% of participants, with 40.7% identifying as average and 8.1% as below average or preferring not to say. The vast majority (88.4%) described themselves as being in a monogamous relationship, and 83.7% reported being in relationships lasting four or more years.

Regarding sexual orientation, 89.5% identified as entirely or largely heterosexual, while 10.5% identified as bisexual, homosexual, or other. Just over a third (38.4%) reported currently being in therapy. Most participants (72.1%) were married or cohabitating, and 66.3% had children either together or from previous relationships, while 7% were planning to have children in the future.

The researchers report that the participants were majorly based in North America, with some in Europe and Africa, although the precise geographic locations were not measured because this was conducted online.

A detailed description of the participants is displayed in **Table 1**: Participant Demographics.

Table 1. Participant demographics.

Characteristic	Category	Frequency (%)
Gender	Female	45 (52.3)
	Male	41 (47.7)
Education	Bachelor's Degree	26 (30.2)
	Master's Degree	21 (24.4)
	Doctoral Degree	13 (15.1)
	Some college	7 (8.1)
	High School Graduate or Equivalent	6 (7.0)
	Professional Diploma	5 (5.8)
	Professional Degree	5 (5.8)
	Other (please specify)	2 (2.3)
Ethnicity	Less than high school	1 (1.2)
	White/Caucasian	72 (83.7)
	Hispanic	6 (7.0)
	Other	3 (3.5)
	Black or African American, White/Caucasian	2 (2.3)

Continued

Employment	White/Caucasian, Hispanic	1 (1.2)
	Asian	1 (1.2)
	Black or African American	1 (1.2)
	Employed full time (21 - 40+ hours per week)	41 (47.7)
	Self-employed	24 (27.9)
	Company owner	7 (8.1)
	Homemaker	4 (4.7)
	Employed part-time (up to 20 hours per week)	3 (3.5)
	Unemployed	3 (3.5)
	Retired	2 (2.3)
Socioeconomic Status	Student	2 (2.3)
	Above average	44 (51.2)
	Average	35 (40.7)
	Below average	4 (4.7)
	Prefer not to say	3 (3.5)
Relationship Type	Monogamous	76 (88.4)
	Romantically monogamous, sexually open	6 (7.0)
	Romantically open, sexually monogamous	3 (3.5)
	Romantically and sexually open	1 (1.2)
Relationship Length	10+ years	50 (58.1)
	7 - 10 years	12 (14.0)
	4 - 6 years	10 (11.6)
	1 - 3 years	9 (10.5)
	Less than a year	5 (5.8)
Sexual Orientation	Entirely heterosexual	59 (68.6)
	Largely heterosexual, but some homosexual desire	18 (20.9)
	Equally heterosexual and homosexual	3 (3.5)
	Largely homosexual, but some heterosexual desire	3 (3.5)
	Other (None of the above apply)	2 (2.3)
	Largely heterosexual, but considerable homosexual desire	1 (1.2)
Currently in Therapy	No	53 (61.6)
	Yes	33 (38.4)
Marital Status	Married/Cohabiting	62 (72.1)
	Not married/Living together	11 (12.8)
	Not married/Not Cohabiting	10 (11.6)

Continued

Children	Engaged/Cohabiting	2 (2.3)
	Other (please specify)	1 (1.2)
	We have children together	46 (53.5)
	No	23 (26.7)
	Myself or my partner have children from previous relationships	11 (12.8)
	Not yet but planning to have them	6 (7.0)

5.2. Weekly Evaluations of Protocol Feasibility, Engagement, and Instructional Clarity

Over the eight-week study period, participants evaluated multiple aspects of the course experience, including relevance, clarity, content and practice engagement, protocol benefit, Zoom satisfaction, and practicality. Descriptive statistics revealed that participants consistently rated the program highly, with several dimensions showing positive trends across time.

Relevance of the content was rated favorably overall ($M = 77.15$, $SD = 5.60$), with scores increasing from approximately 71 in Week 1 to a peak of 82.9 by Week 6. Protocol benefit exhibited the most marked improvement, rising steadily from a low of 46.3 in Week 1 to a high of 79.0 by Week 7 ($M = 65.88$, $SD = 12.51$), suggesting that perceived value of the intervention grew as participants progressed. Ratings for clarity remained consistently high throughout the program ($M = 89.51$, $SD = 1.40$), with all weekly scores exceeding 87, indicating strong instructional quality. Content engagement was also strong ($M = 79.06$, $SD = 3.29$), peaking at 83.8 in Week 4 and tapering slightly in later sessions. Practice engagement followed a similar pattern, remaining consistently high ($M = 78.86$, $SD = 2.74$) with a peak of 83.3 in Week 4. Participants reported increasing Zoom satisfaction over time ($M = 79.70$, $SD = 6.15$), beginning at 71.5 and climbing to 87.3 by Week 7. Ratings for practicality improved as well, with an overall mean of 70.44 ($SD = 6.96$); scores rose from a low of 59.2 in Week 1 to a stable range in the mid-70s during the final sessions (see **Table 2**: Weekly Engagement of Protocol Feasibility, Engagement, and Instructional Clarity).

Table 2. Weekly evaluations of protocol feasibility, engagement, and instructional clarity.

Week index	Sample size	Relevance (0 - 100)	Protocol benefit (0 - 100)	Clarity (0 - 100)	Content engagement (0 - 100)	Practice engagement (0 - 100)	Zoom satisfaction (0 - 100)	Practicality (0 - 100)
1	82	70.8	46.3	88.3	75.7	75.8	71.5	59.2
2	82	70.6	52.3	90.3	76.4	75.4	71.8	66.7
3	75	71.4	57.6	89.1	77	78.5	74.6	61.8
4	73	81.4	66.5	89.8	83.8	83.3	82	72.8
5	60	82.6	70.8	90.6	81.8	79.8	82	76.4
6	41	82.9	75.9	91.8	82.7	81.6	84.2	77.4
7	35	81.7	79	88.8	79.2	79.3	87.3	74.3
8	29	75.8	78.6	87.4	75.9	77.2	84.2	74.9

5.3. Secondary Outcomes: Sexual Well-Being and Functioning

In addition to primary outcomes, secondary analyses explored shifts in sexual satisfaction, communication, function, intimacy, and relational dynamics. Standardized pre/post measures (Section 5.4) revealed statistically significant improvements in sexual pleasure, emotional closeness, and self-perceived confidence. Baseline-to-endpoint comparisons (Section 5.5) confirmed gains across validated instruments such as the NSSS, DSCS, FSFI-S, and TLS-15. Exploratory self-constructed metrics (Section 5.6) further illuminated increases in sexual frequency, duration, novelty, confidence, and intimacy—providing a nuanced picture of the intervention's impact on partnered erotic vitality and emotional connection.

5.4. Validated Pre/Post Measures

Across the eight-week intervention, participants demonstrated statistically significant improvements in multiple domains of sexual satisfaction, intimacy, communication, and function. Gains were most pronounced in overall sexual satisfaction and relational connection, with supporting improvements in sexual communication, emotional closeness, and self-perception in partnership.

Participants reported meaningful increases on the New Sexual Satisfaction Scale (NSSS). The *Personal Sexual Satisfaction* subscale rose from a baseline mean (M) of 22.22 (SD = 9.06) to 31.46 (SD = 10.84), while *Partner and Activity Satisfaction* increased from M = 23.18 (SD = 9.70) to 31.39 (SD = 12.16); both changes were highly significant ($p < 0.001$). Overall, *Total NSSS scores* improved from M = 46.10 (SD = 17.63) to 62.86 (SD = 22.09), $V = 230.5$, $p < 0.001$, indicating broad enhancement in sexual pleasure and fulfillment.

Relational communication also improved significantly. On the Dyadic Sexual Communication Scale (DSCS), participants' scores increased from M = 26.32 (SD = 7.90) to M = 30.41 (SD = 7.45), $V = 403.5$, $p < 0.001$, suggesting greater openness and quality in intimate dialogue with partners.

Improvements in sexual function varied by gender. Among females, the FSFI-6 revealed statistically significant gains in orgasm ($V = 14$, $p < 0.001$), arousal ($V = 45.5$, $p < 0.001$), and satisfaction ($V = 55.5$, $p < 0.01$). Total FSFI-S scores increased from M = 12.78 (SE = 0.86) to 15.49 (SE = 1.04), $V = 133.5$, $p < 0.01$. However, *Desire* scores significantly decreased ($V = 419.5$, $p = 0.011$), and *Pain* scores remained unchanged ($V = 78.5$, $p = 0.599$), indicating nuanced shifts in functional aspects of arousal. Among males, scores on the IIEF-5 increased modestly from M = 17.56 (SD = 4.52) to M = 19.06 (SD = 4.68), though this trend did not reach statistical significance ($V = 134.5$, $p = 0.07$).

Exploring the emotional-psychological dimensions, attachment style remained stable throughout the intervention. On the Experiences in Close Relationships Scale (ECRS), *Attachment Anxiety* changed minimally (M = 8.29 to 8.17, $p = 0.699$), and *Attachment Avoidance* decreased slightly (M = 7.69 to 7.18, $p = 0.883$), indicating no significant shifts in deep relational patterning over this short-term period.

Positive gains were also observed on the Triangular Love Scale (TLS-15). Par-

ticipants showed increases in *Intimacy* ($M = 19.90$ to 20.49 , $p = 0.006$) and *Passion* ($M = 17.23$ to 18.54 , $p = 0.003$), with the *Total TLS score* rising from $M = 59.03$ ($SD = 10.15$) to 60.93 ($SD = 12.00$), $p = 0.011$. *Commitment* remained stable. These findings suggest a revitalization of emotional closeness and erotic vitality, even in the absence of major shifts in long-term commitment.

The Inclusion of Other in the Self (IOS) scores rose significantly from $M = 3.77$ ($SD = 1.64$) to $M = 4.33$ ($SD = 1.66$), $p = 0.015$. This shift reflects a deeper sense of relational merging and perceived partner closeness—an important factor in emotional and sexual intimacy.

Type III repeated-measures Analysis of Variance using Satterthwaite’s approximation for degrees of freedom revealed statistically significant effects over time for several domains of sexual well-being. Specifically, improvements remained significant after false discovery rate (FDR) correction in sexual satisfaction ($p < 0.001$), emotional closeness ($p < 0.001$), sex drive ($p = 0.012$), sexual confidence ($p = 0.002$), and sexual communication ($p = 0.003$). The increase in sexual enjoyment did not retain significance after correction (see Table 3).

Table 3. Analysis of variance.

Type III analysis of variance with Satterthwaite’s method	Significance of the model (before controlling for multiple comparisons)
Enjoyment	0.0971
Satisfaction	$p < 0.001$ ***
Emotional Closeness	$p < 0.001$ ***
Sex drive	0.0119 *
Confidence	0.002 **
Sexual Communication	0.003 **

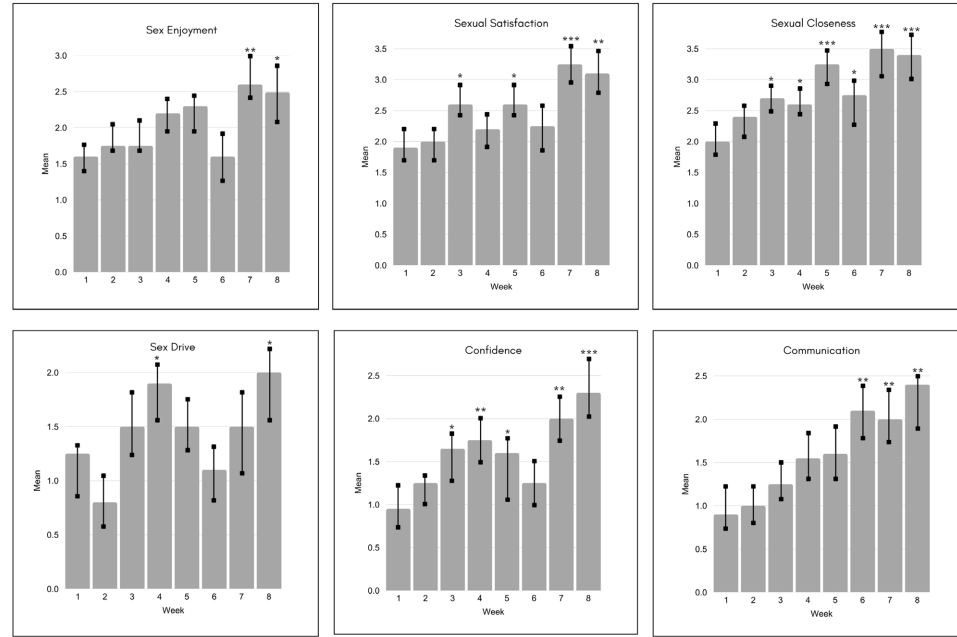


Figure 2. Weekly psychosexual outcomes (EMA).

These trends are illustrated in **Figure 2** Weekly Psychosexual Outcomes (EMA), which depicts changes in sexual satisfaction, emotional closeness, sex drive, sexual confidence, and dyadic communication measured weekly across the eight-week intervention using Ecological Momentary Assessments (EMA). The figure presents estimated marginal means for each domain—enjoyment, satisfaction, closeness, drive, confidence, and communication—over the course of the program. Error bars represent the standard error of the mean (SEM). Statistically significant differences are indicated by asterisks, where * represents $p < 0.05$, ** $p < 0.01$, and *** $p < 0.005$.

Sexual satisfaction significantly increased in both personal and partner-oriented domains (NSSS). *Sexual communication* improved markedly, indicating better relational dialogue (DSCS). *Female sexual function* improved significantly in orgasm, arousal, and satisfaction (FSFI-S), though desire declined, as further discussed in Section 6.2. *Emotional intimacy and passion* increased (TLS), while attachment patterns remained stable (ECRS). *Perceived partner closeness* improved (IOS), supporting enhanced intimacy. *Sexual confidence, drive, and emotional closeness* showed sustained gains across the intervention.

5.5. Baseline vs. End-of-Protocol Results

Statistical analysis using the Wilcoxon signed-rank test revealed significant improvements across multiple domains of sexual wellbeing between baseline and end-of-protocol assessments.

Sexual Satisfaction

Participants reported significant gains in sexual satisfaction as measured by the New Sexual Satisfaction Scale (NSSS). The Personal Satisfaction subscale increased from $M = 22.22$ ($SD = 9.06$) to $M = 31.46$ ($SD = 10.84$), $V = 208.5$, $p < 0.001$. The Partner & Activity Satisfaction subscale rose from $M = 23.18$ ($SD = 9.70$) to $M = 31.39$ ($SD = 12.16$), $V = 166.5$, $p < 0.001$. The Total Sexual Satisfaction score significantly increased from $M = 46.10$ ($SD = 17.63$) to $M = 62.86$ ($SD = 22.09$), $V = 230.5$, $p < 0.001$.

Sexual Communication

The Dyadic Sexual Communication Scale (DSCS) showed a significant increase from $M = 26.32$ ($SD = 7.90$) to $M = 30.41$ ($SD = 7.45$), $V = 403.5$, $p < 0.001$, indicating enhanced clarity, openness, and emotional safety in sexual dialogues between partners.

Love and Relationship Quality (TLS-15)

The Triangular Love Scale revealed a modest but significant increase in Intimacy ($M = 19.90$ to 20.49 ; $V = 523$, $p = 0.006$) and Passion ($M = 17.23$ to 18.54 ; $V = 459.5$, $p = 0.003$). However, Commitment remained stable ($M = 21.91$ to 21.90 ; $V = 675.5$, $p = 0.725$). The Total Love score increased significantly from $M = 59.03$ ($SD = 10.15$) to $M = 60.93$ ($SD = 12.00$), $V = 732.5$, $p = 0.011$.

Sexual Functioning

In women, the Female Sexual Function Index—Short Form (FSFI-S) showed significant improvement, with mean scores increasing from 12.78 ($SE = 0.86$) to

15.49 (SE = 1.04), $V = 133.5$, $p < 0.01$. Subdomain analysis showed significant improvements in orgasm ($V = 14$, $p < 0.001$), arousal ($V = 45.5$, $p < 0.001$), and satisfaction ($V = 55.5$, $p < 0.01$). No significant changes were observed in pain ($V = 78.5$, $p = 0.599$), while desire scores decreased significantly ($V = 419.5$, $p = 0.011$). Among men, changes in the International Index of Erectile Function (IIEF-5) were modest and not statistically significant, with scores rising from $M = 17.56$ (SD = 4.52) to $M = 19.06$ (SD = 4.68), $V = 134.5$, $p = 0.07$.

Attachment

Attachment-related measures, as assessed by the Experiences in Close Relationships Scale—Short Form (ECR-S), showed no significant changes. Attachment Anxiety decreased slightly ($M = 8.29$ to 8.17 ; $V = 875.5$, $p = 0.699$), and Attachment Avoidance declined from $M = 7.69$ to 7.18 ($V = 725$, $p = 0.883$), but neither change reached statistical significance. These results collectively highlight the intervention's significant impact on personal and relational sexual wellbeing, with the strongest gains in sexual satisfaction, communication, and specific components of relational intimacy.

Detailed results are visualized in **Figure 3**: Changes in Validated Psychosexual Scales.

As illustrated in **Figure 3**, statistically significant improvements were observed in multiple validated psychosexual domains following the intervention. These included **sexual satisfaction** as measured by the New Sexual Satisfaction Scale (NSSS, $p < 0.001$), **sexual communication** via the Dyadic Sexual Communication Scale (DSCS, $p < 0.001$), **intimacy and passion** assessed by the Triangular Love Scale (TLS-15, $p < 0.01$), and **female orgasmic function** measured by the Female Sexual Function Index Short Form (FSFI-5, $p < 0.001$). Additionally, participants reported significant gains in **penetration length and sexual duration** ($p < 0.001$). Notably, **male erectile function** (IIEF-5) did not show significant change, which may be attributed to normative erectile function reported at baseline.

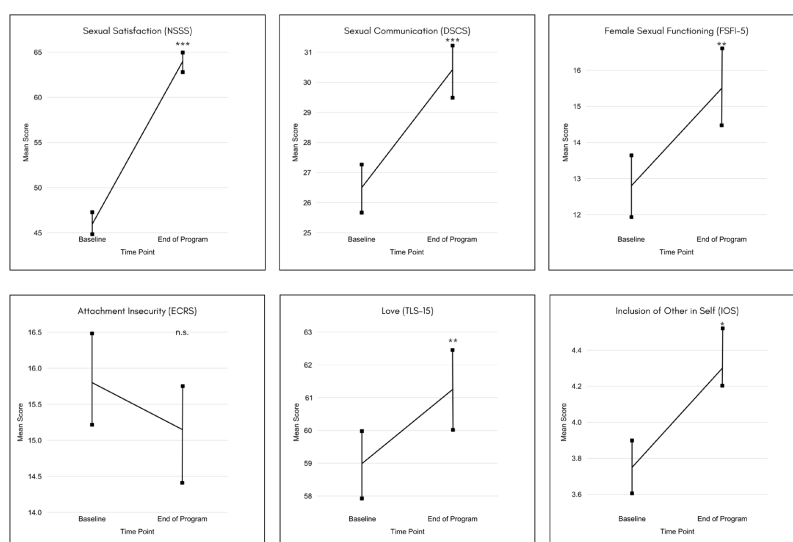
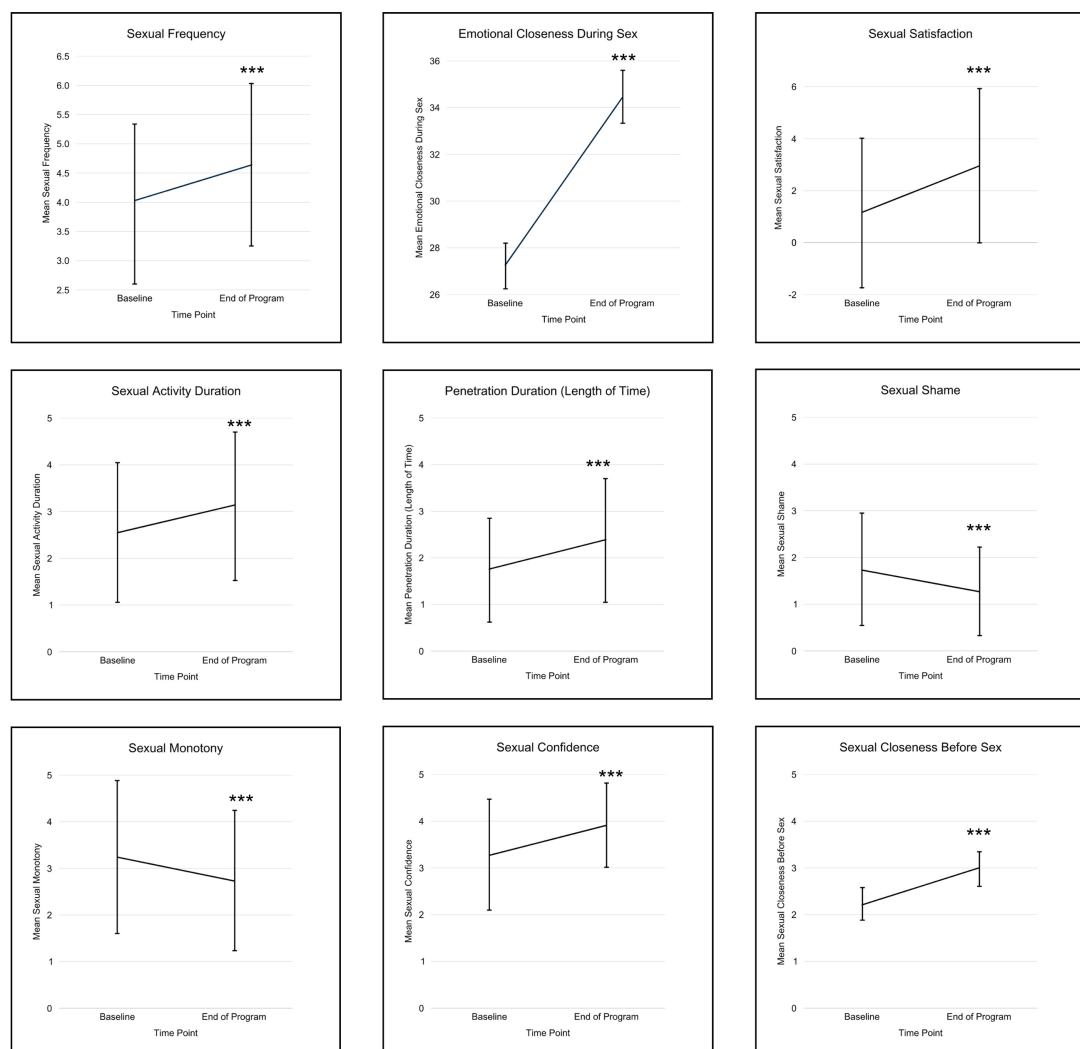


Figure 3. Changes in validated psychosexual scales.

Figure 3 Pre- to post-intervention changes in validated psychosexual measures, including the NSSS, DSCS, FSFI-5, TLS-15, and IOS. Higher scores indicate greater satisfaction, intimacy, and connection. Error bars represent standard error of the mean (SEM). Statistically significant differences are denoted by asterisks: $p < 0.05$, $p < 0.01$, and $p < 0.005$.

5.6. Exploratory Self-Constructed Outcomes

In addition to validated psychometric instruments, a set of exploratory, researcher-constructed items was included to assess nuanced aspects of participants' psychosexual experiences. These items, while not standardized, provide rich insight into behavioral, emotional, and relational dynamics not captured by traditional measures. Each item was assessed using Likert-style response formats, with higher scores reflecting more favorable outcomes unless otherwise noted. Changes from baseline to end-of-protocol were analyzed using Wilcoxon signed-rank tests. Results are summarized below and visually depicted in **Figure 4**: Changes in Self-Constructed Sexual Outcomes.



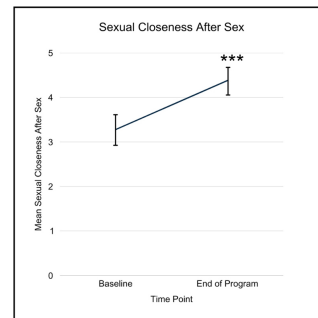


Figure 4. Changes in self-constructed sexual outcomes.

Figure 4 Pre- to post-intervention changes in self-constructed sexual wellness outcomes, including frequency of sexual activity, average sexual duration, average penetration duration, sexual novelty engagement, sexual confidence, and reduction in sexual shame. Higher scores reflect improvements unless otherwise noted. Error bars represent standard error of the mean (SEM). Statistically significant differences were marked with asterisks, where * represents $p < 0.05$, ** $p < 0.01$, and *** $p < 0.005$.

Participants demonstrated statistically significant improvements across multiple domains of sexual functioning, behavior, and intimacy. In response to the question, “*What is your frequency of sexual activity (intercourse, caressing, foreplay & masturbation) with your partner?*”, participants reported an increase in mean scores from 4.03 (SD = 1.38) to 4.64 (SD = 1.42), $p = 0.0012$, indicating a modest but meaningful increase in the frequency of partnered sexual activity. Regarding duration, the question “*What is your average length of a sexual activity (intercourse, caressing, foreplay & masturbation)?*” yielded a significant increase in average duration from 2.55 (SD = 1.52) to 3.14 (SD = 1.61), $p = 0.004$, reflecting a shift from the 5 - 15 minute range to the 15 - 30 minute range, suggesting more time invested in arousal, connection, and physical intimacy.

Penetrative sexual activity also saw meaningful gains. In response to “*What is your average length of sexual intercourse (defined as sexual penetration vaginally or anally)?*”, mean scores rose from 1.76 (SD = 1.13) to 2.39 (SD = 1.34), $p = 0.0023$, marking a shift from less than 5 minutes toward the 5 - 15 minute duration range. Participants were also asked, “*Do you feel that your sexual experiences have become routine or predictable?*”; responses to this item decreased significantly from 3.24 (SD = 1.67) to 2.73 (SD = 1.52), $p = 0.005$, indicating a decline in perceived routine and an increase in sexual novelty and spontaneity.

On the emotional and psychological dimensions of sexuality, the question “*It is difficult for me to fully enjoy sexual experiences due to shame*” revealed a significant reduction in shame-related interference, with mean scores decreasing from 1.73 (SD = 1.18) to 1.27 (SD = 0.96), $p < 0.0002$. This suggests enhanced emotional comfort, self-acceptance, and a reduction in internalized barriers to pleasure. Likewise, in response to “*I have confidence in myself as a sexual partner*”, participants reported increased confidence, with scores rising from 3.27 (SD = 1.20) to

3.91 (SD = 0.90), $p < 0.00002$, indicating stronger self-assurance regarding one's sexual abilities and relational competence.

Global sexual fulfillment was assessed with the item, *"How would you rank your experience of sex at this moment in your life?"* Mean scores improved substantially from 1.17 (SD = 2.86) at baseline to 2.95 (SD = 3.01) at program completion, $p < 0.0001$, suggesting a significant increase in perceived sexual satisfaction. Emotional intimacy was assessed using the question, *"How emotionally connected do you feel to your partner during sex?"*, with scores rising from 27.26 (SE = 0.95) to 34.42 (SE = 1.16), $V = 322.5$, $p < 0.001$, according to the Aaron Michael and Saida Désilets Method Intimacy Scale. Emotional attunement before sexual activity was measured with the item, *"How emotionally close do you feel to your partner before sex begins?"*, which saw a significant increase from 2.21 (SE = 0.37) to 3.00 (SE = 0.38), $V = 589$, $p < 0.001$. Finally, post-coital connection improved as well, with responses to *"How emotionally close do you feel to your partner after sex ends?"* increasing from 3.28 (SE = 0.34) to 4.38 (SE = 0.34), $V = 366$, $p < 0.001$, highlighting enhanced emotional closeness and satisfaction following intimacy.

Collectively, these self-constructed measures offer important behavioral and experiential context to complement the standardized psychometric outcomes. Each demonstrated statistically significant improvement, reinforcing the feasibility, engagement, and early effectiveness of this somatic and psychosexual protocol for enhancing intimacy and partnered sexual wellbeing.

6. Discussion

The findings of this feasibility study indicate that the ESM and EPSM—delivered through a hybrid model combining pre-recorded educational material with live virtual sessions—is both practical and efficacious in enhancing sexual satisfaction, intimacy, and embodied erotic functioning. Participant engagement remained high, with low attrition and strong adherence to the experiential components. The results point to the potential of this protocol not merely as a treatment for dysfunction but as a holistic model for sexual optimization.

Significant improvements were observed across a wide range of self-reported domains, including sexual frequency, duration, penetration length, confidence, and intimacy. Notably, scores on the Penetration Protocol Intimacy Scale and indicators of sexual closeness before and after sex also increased significantly. These outcomes align with growing evidence that sexual wellness interventions targeting embodied practices and communication can meaningfully enhance not only sexual functioning but also relationship quality and emotional connection [65]–[67]. (The improvements in sexual communication—measured by validated metrics such as the DSCS—suggest that participants acquired the emotional literacy and embodied consent skills necessary to express their desires and boundaries with greater clarity and attunement).

Unlike conventional protocols that focus primarily on reducing symptoms of dysfunction, the Penetration Protocol—built on Embodied Psychosexual Method

(EPSM) and Enactive Sexual Method (ESM)—addresses root causes of sexual dissatisfaction through psychosexual education, somatic repatterning, and nervous system regulation. This model incorporates pelvic floor training, breathwork, guided journaling, meditative practices, hip coordination, and embodied communication. The goal is not simply the restoration of normative function but the awakening of erotic intelligence and integration of sexual identity.

These multidimensional changes are noteworthy not only for their depth but for their relevance to both clinical and lifestyle medicine contexts. For example, participants demonstrated a shift from friction-based sexual mechanics to suction-based engagement, a somatically-informed innovation that appeared to increase mutual pleasure and alleviate performance anxiety. Further, the reduction in sexual shame and routineness—paired with gains in sexual confidence—indicates the protocol may effectively address psychosocial barriers to intimacy and joy.

A key strength of this work lies in its applicability within a concierge integrative medical framework. Participants benefited from a trauma-informed and pleasure-inclusive model that can easily interface with regenerative medical care. The hybrid format also allowed for flexible access and personalized pacing, increasing feasibility for diverse populations and offering a scalable adjunct to individualized concierge care.

While the female participants demonstrated statistically significant improvements on FSFI-S subdomains (notably orgasm, arousal, and satisfaction), the unexpected reduction in spontaneous desire scores reflects emerging understandings of responsive desire models [68] [69]. This finding also challenges conventional assumptions in sexual medicine, highlighting the importance of shifting focus from frequency-based metrics to satisfaction, intimacy, and sexual agency.

6.1. Preliminary Psychometric Evaluation of Structured Sexual Novelty Engagement

Sexual novelty was assessed through exploratory self-report items designed to capture participants' engagement with new, varied, and less routine sexual behaviors. Unlike most studies examining sexual satisfaction—which typically measure static relational dynamics without actively introducing novel practices—this intervention uniquely guided participants through structured, embodied exercises intended to fundamentally reshape their sexual experiences.

Although formal psychometric validation of the novelty items was beyond the scope of this feasibility study, several factors support their preliminary psychometric soundness. First, strong face validity was evident: the items directly queried participants' engagement with novel and varied sexual experiences, closely aligning with established conceptualizations of novelty as a central driver of sexual passion, fulfillment, and relational vitality [70] [71].

Second, preliminary evidence of convergent validity was observed. Participants who reported greater increases in sexual novelty also exhibited significant gains in sexual satisfaction, orgasm frequency, emotional intimacy, and relational closeness. These findings are consistent with prior research demonstrating that nov-

elty-seeking behaviors promote sustained psychosexual and relational health [72]. Importantly, sexual confidence increased alongside engagement with novel behaviors, suggesting that the practices fostered erotic empowerment rather than anxiety or avoidance.

Third, preliminary discriminant validity was suggested by independent reductions in sexual shame, indicating that the novelty items captured a distinct construct related to positive expansion of erotic repertoire, rather than merely reflecting decreased inhibition.

Given its promising association with enhanced sexual satisfaction, emotional intimacy, and relational vitality, structured sexual novelty merits formal integration as a core therapeutic target within future psychosexual intervention frameworks. Future research should prioritize the development and validation of a dedicated sexual novelty scale, including assessments of internal consistency, test-retest reliability, factor structure, and predictive validity, to enable more rigorous evaluation of structured novelty as an intervention component in sexual and relational health.

6.2. Interpreting the Decline in Female Desire Scores: Erotic Satiety and Neuroendocrine Dynamics

Following the intervention, a decline in female FSFI-S Desire scores was observed, despite significant improvements in orgasm frequency, sexual satisfaction, emotional intimacy, and engagement with novel sexual practices. Although initially appearing paradoxical, this pattern likely reflects a state of sexual satiety rather than dysfunction or diminished relational eroticism.

Evidence from neuroendocrine studies suggests that orgasmic activity—particularly involving penetrative intercourse—is associated with transient elevations in prolactin, a neurohormone linked to sexual satiation and reduced dopaminergic sexual motivation [73] [74]. While prolactin spikes post-orgasm are more pronounced in men, women also exhibit significant elevations following orgasm, especially after penetrative stimulation [75]. Elevated prolactin levels are known to dampen immediate sexual motivation, aligning with the observed post-intervention decline in spontaneous desire.

Moreover, although male orgasm frequency was not directly assessed in this study, the increase in reported sexual activity suggests that male partners may also have experienced heightened prolactin-driven satiety. Reduced initiation energy from male partners—secondary to their own satiety—could indirectly modulate female partners' subjective experience of desire, consistent with relational models of female sexual motivation that emphasize contextual and responsive dynamics [76].

Thus, rather than signaling a deficit in sexual function, the observed decrease in desire scores likely reflects an adaptive biological and relational interplay: the culmination of successful erotic engagement resulting in temporary neuroendocrine and relational satiety. Future research incorporating longitudinal hormonal tracking (e.g., prolactin, dopamine, oxytocin) alongside qualitative analyses of

subjective sexual satiety would provide deeper insights into the cyclical, self-regulating nature of desire following intensive sexual satisfaction interventions.

6.3. Limitations

While this feasibility study yielded promising findings, several limitations must be acknowledged. First, the sample size, though adequate for initial analysis, limits the generalizability of the results. The majority of participants identified as White/Caucasian and heterosexual, which may not reflect the broader diversity of sexual orientations, ethnic backgrounds, or gender identities. Additionally, participants self-selected into the study, introducing potential selection bias—those already inclined toward integrative or somatic healing modalities may be more likely to respond positively to such an intervention.

Another limitation lies in the hybrid format of delivery, which, while accessible and flexible, may not provide consistent therapeutic conditions across participants. Variability in how and when participants engaged with pre-recorded materials, as well as differences in their environments during live sessions, could have influenced outcomes. Furthermore, the optional nature of weekly assessments and the presence of concurrent therapies among some participants make it difficult to isolate the specific effects of the Aaron Michael and Saida Désilets Method within this context.

6.4. Delimitations

This study intentionally focused on individuals and couples experiencing mild to moderate sexual dissatisfaction, rather than those with formally diagnosed sexual dysfunction. Diagnosing sexual dysfunction typically requires symptoms to persist for at least six months as well as an accompanying measure of sexual distress, which were not accounted for in this study [77]. This delimitation was chosen to evaluate the accessibility and efficacy of the method as a preventative, educational, and growth-oriented intervention rather than a clinical treatment for severe dysfunction. The study also restricted participation to English-speaking individuals with access to stable internet and digital literacy to accommodate the hybrid online format.

Additionally, while an integrative protocol includes options for regenerative medicine, neuromodulation, lifestyle enhancements, and optional entheogenic in legal and supervised jurisdictions, this study did not formally assess or include these elements. These components are discussed as future directions rather than directly evaluated in this iteration. The scope of this study was further narrowed to long-term partners due to protocol development logistics and measurement constraints in this pilot phase.

6.5. Potential Biases

Several forms of bias may have influenced findings. Response bias is possible given that participants were offered partial reimbursement for completing both baseline

and post-program assessments, potentially incentivizing more favorable self-reporting. Social desirability bias may also have affected participant responses to intimate or sensitive questions, especially in the absence of anonymity during group sessions.

Confirmation bias is a possible influence among facilitators or co-researchers invested in the success of ESM and EPSM. Although outcome measures included validated tools and statistical analysis was blinded, the developmental proximity of investigators to the intervention introduces potential subjectivity in interpretation. Future iterations should include independent evaluators and, where possible, a randomized controlled trial design to mitigate this bias.

6.6. Future Research and Development

The promising outcomes observed in the initial feasibility study of the Penetration Protocol suggest a robust foundation for further research. Future directions include replicating the study with a larger and more diverse participant population across varying geographic regions. Incorporating a randomized control group design would strengthen the evidence base and provide comparative insights into the efficacy of the Penetration Protocol relative to other psychosexual interventions.

It is important to emphasize that the Penetration Protocol represents just one application of a broader synthesis between the Embodied Psychosexual Method (EPSM) and the Enactive Sexual Method (ESM). Given the multidimensional framework of these two systems, there exists substantial potential to develop additional protocols tailored to specific sexual dysfunctions—such as vaginismus, anorgasmia, erectile dysfunction, premature ejaculation, or post-traumatic penetration anxiety. Notably, a preliminary observational study by Dr. Saida Désilets has demonstrated that EPSM-based practices can result in measurable physiological changes. In this study, women exposed to EPSM demonstrated measurable physiological changes in the Skene's glands—specifically, in the quantity and distribution of glandular ostia on the bilateral aspects of the urethral meatus—as verified through pre- and post-intervention pelvic examinations using a video colposcope. This suggests a direct correlation between psychosexual therapeutic frameworks and somatic outcomes.

6.7. Regenerative Medicine Synergies with Psychosexual Therapy: Rationale and Future Directions

Building on the significant improvements observed in sexual satisfaction, emotional intimacy, orgasmic function, and relational closeness, there remains an opportunity to further optimize outcomes by addressing the underlying biological foundations of sexual vitality. Integrating regenerative medical approaches alongside psychosexual education may offer synergistic benefits, uniting cellular rejuvenation with embodied relational growth. Emerging evidence provides compelling mechanistic support for this integrative model, as outlined below.

While the current study did not formally evaluate adjunctive regenerative ther-

apies, strong biological rationale and preliminary clinical observations suggest that combining psychosexual interventions with cellular regenerative modalities could meaningfully enhance sexual function, emotional intimacy, and relational wellbeing. Healing modalities include, but are not limited to, the following:

Extracorporeal blood oxygenation and ozonation (EBOO) has been shown to improve systemic oxygenation, reduce vascular inflammation, and restore endothelial function [78], given the centrality of endothelial health to sexual arousal and erectile function. Improvements in vascular integrity through EBOO may potentiate gains in sexual vitality [79].

NAD⁺ intravenous infusions support mitochondrial biogenesis, oxidative stress reduction, and neurovascular resilience. Sexual arousal, orgasmic capacity, and erectile quality are energy-dependent processes requiring optimal mitochondrial ATP production. NAD⁺ replenishment may thus bolster the cellular energy required for psychosexual flourishing, particularly in aging or metabolically compromised individuals [80].

Laser-activated platelet-rich plasma (PRP) facilitates targeted tissue regeneration, beginning with a simple blood draw. The patient's own blood is centrifuged to isolate the PRP, which is then exposed to specific wavelengths of laser light to enhance its regenerative properties before being reintroduced into the body. PRP is rich in growth factors that stimulate angiogenesis, fibroblast proliferation, and nerve regeneration [81]. When administered systemically and/or locally to penile or vaginal tissues, PRP has been shown to increase blood flow, sensitivity, tissue elasticity, and sexual pleasure [82]. Laser activation enhances PRP's bioactivity, optimizing growth factor release and tissue repair [83].

Together, these regenerative modalities may address the cellular, vascular, and neurophysiological foundations of sexual function, complementing the somatic, emotional, and relational growth fostered through psychosexual education. Their thoughtful integration represents a promising frontier for optimizing multidimensional sexual health.

Future Directions

Building on these mechanistic insights, future pilot studies should systematically evaluate the impact of combined regenerative and psychosexual interventions. Prospective trials could incorporate biomarkers of vascular function (e.g., flow-mediated dilation), mitochondrial health (e.g., NAD⁺/ATP ratios), and objective sexual function outcomes (e.g., FSFI, IIEF), alongside qualitative measures of sexual satisfaction and relational closeness. Such investigations could formally establish the synergistic potential of regenerative and psychosexual therapies for restoring and optimizing erotic vitality across the lifespan. As more case studies are conducted, findings can be used to refine specific protocols based on individual conditions, age groups, trauma histories, and relational dynamics. Iterative development through clinical feedback loops will allow for targeted adaptations of the Penetration Protocol and its related applications, ultimately evolving into a suite of personalized therapeutic offerings.

Furthermore, the collaborative concierge model developed through this work presents an innovative template for interdisciplinary care and education. Future plans include presenting these findings and protocols at continuing medical education (CME) conferences to encourage knowledge transfer and interprofessional collaboration across fields such as sexual medicine, integrative health, psychology, urology, gynecology, and somatic therapy.

Finally, the development of an educational platform—tentatively titled *Embodied Love University*—is underway to provide scalable access to this work. This platform could include open-access materials for the general public, professional training modules for clinicians, and developmentally appropriate content tailored for adolescent sexual education. By offering a more comprehensive, empowering, and scientifically informed approach to human sexuality, this work has the potential to reshape how both patients and providers understand the role of sexual well-being in holistic health.

7. Integrative Concierge Medical Framework for Sexual Wellness Optimization

To responsibly implement the psychosexual gains of the Penetration Protocol in a clinically effective and safe manner, a concierge medical framework can offer the necessary foundation for comprehensive, individualized care. This model bridges the psychological and somatic realms of sexual transformation with regenerative, cellular-level interventions provided by a licensed physician operating within a high-touch, patient-centered setting.

A concierge physician trained in regenerative medicine can provide medical screening for underlying pathologies—such as hormonal imbalances, vascular insufficiencies, neuropathies, pelvic floor dysfunction, and inflammatory disorders—that often contribute to sexual dysfunction but remain underdiagnosed in conventional care [84]. Such screening enhances the safety and efficacy of somatic and psychosexual interventions by offering a physiological map to guide therapeutic precision.

The synergy of somatic sex therapy with medical regeneration becomes particularly valuable when integrated into an intensive, daily, weeklong deep-dive format— or longer, as commitment and resources allow. In this setting, participants receive highly individualized care, including:

- Advanced diagnostics tailored to the individual, including hormonal panels, nutrient markers, vascular studies, mycotoxin or mold screening, and metabolic assessments to create a holistic picture of internal health.
- Manual and structural bodywork, Chi Nei Tsang abdominal massage, and postural alignment protocols to support the biomechanics of sexual movement and alleviate pain [85].
- Cellular and regenerative therapies, such as extracorporeal blood oxygenation and ozonation (EBOO), NAD⁺ and nutrient infusions—culminating at the conclusion of the week-long intensive with laser-activated platelet-rich plasma

(PRP) (delivered systemically into the whole body, and locally into male/female anatomical structures, face, joints, and/or scalp) to support tissue rejuvenation, neurovascular health, and sexual vitality [86] [87]. Guided imagery and a peak state induction or invocation achieved via medical hypnosis may empower the recipients to focus on and participate in their own specific healing and regeneration objectives.

- Neuromodulation therapies, such as microcurrent therapy (MCT) [88], Neurogen brain balancing (NGBB) [89], Chi Nei Tsang abdominal organ massage, craniosacral therapy, to enhance autonomic regulation and emotional resilience [90].

Curated mind-body therapies support the lasting benefits of regenerative sexual wellness protocols. Practices such as yoga, breath-centered movement, forest bathing, and guided nature immersion activate the parasympathetic nervous system, enhance interoception, and promote emotional recalibration. These experiences reduce cortisol, boost mood, and foster oxytocin-mediated social bonding—key to sexual vitality and neuroendocrine health. Nutrient-dense, anti-inflammatory meals tailored to individual metabolic needs further sustain hormonal and cognitive balance. For individuals seeking deeper healing, legal, professionally guided entheogenic ceremonies, may provide potent access to archetypal and relational material beyond the reach of conventional. When responsibly integrated, these approaches deepen somatic integration, support trauma resolution, and reinforce a holistic vision of embodied, relational, and ecological well being [91].

Delivered in a personalized luxury wellness setting—or even in the comfort of the patient’s own home—this concierge model offers more time, depth, and connection than the average clinical visit—an interpersonally engaged, deep-dive approach permitting meaningful transformation rather than time-constrained, superficial symptom management. It also fosters a multidisciplinary care team, where physicians, psychosexual therapists, and wellness practitioners work in tandem, sharing clinical data, and co-designing treatment plans.

Ultimately, by combining the Enactive Sexual Method (ESM) and the Embodied Psychosexual Method (EPSM) with high-level diagnostics and regenerative medicine, the concierge framework allows for deep, sustainable sexual healing and performance optimization. This model supports the whole person—biologically, psychologically, emotionally, and erotically—and represents an emerging gold standard in integrative sexual wellness.

7.1. Sexual Wellness Lifestyle Integration and Environmental Detoxification

Long-term optimization of sexual vitality requires more than clinical intervention; it depends on the cultivation of a supportive internal and external environment that sustains neuroendocrine health, somatic resilience, and erotic well-being. As a follow up to intensive regenerative interventions—patients benefit most when followed by integrative lifestyle enhancements that reinforce healing and pleasure.

A primary pillar of this lifestyle integration is **environmental detoxification**. Endocrine-disrupting chemicals (EDCs), including volatile organic compounds (VOCs), phthalates, and flame retardants, are widely present in memory foam mattresses, synthetic body products, and household furnishings. All of these have been associated with hormonal dysregulation, decreased libido, and reproductive dysfunction [92]. Patients are encouraged to remove memory foam bedding, install HEPA and activated carbon air filters, and utilize reverse osmosis or structured water filtration to reduce exposure to airborne and waterborne toxicants. Body care products—such as lubricants, soaps, and deodorants—should be switched to preservative-free, non-toxic, and ideally edible alternatives that preserve mucosal integrity and avoid microbiome disruption.

Additional lifestyle enhancements and sexual wellness resources are becoming increasingly accessible. Discernment must be applied to ensure these are clinically tested, non-toxic, or have some functional benefit. In addition the jade egg work pioneered by Dr. Saida Désilets, other examples include: (1) the Original Tantra Chair®, developed to support ergonomic intimacy, in the shape of a horizontal “S-shaped” double wave, allowing for optimal spine and pelvic alignment during partnered intimacy, and improving biomechanical engagement and reducing strain [93]; (2) Love Body Butter, composed of edible, therapeutic-grade coconut oils and cacao butters, offers a hormone-safe alternative for moisturization and lubrication, particularly beneficial for perimenopausal and postmenopausal individuals [94]; (3) For male patients undergoing the autologous PRP-based penile injections, the routine use of a penile pump (vacuum erection device) has been shown to support tissue remodeling, promote neovascularization, and maintain erectile strength, such as the clinically tested device by Dr. Joel Kaplan [95].

Daily somatic, contemplative practices—such as pelvic floor breathing, micro-movements, and heart-pelvic meditations—are encouraged to enhance vagal tone, interoceptive awareness, and emotional regulation. These techniques not only support parasympathetic dominance (essential for arousal) but also foster embodiment and erotic confidence. For couples, intentional intimacy rituals, such as synchronized breathing, eye gazing, or sensual touch games, may reinforce emotional safety and deepen relational presence, aligning with the relational goals of the Penetration Protocol.

Personalized nutritional and supplement strategies can also play a supportive role. Depending on individualized lab diagnostics, patients may be prescribed targeted nutrients such as zinc, L-citrulline, and vitamin D₃ for sexual function and hormonal balance, omega-3 fatty acids for neurovascular integrity, and adaptogens like ashwagandha or maca to support libido and stress modulation.

When implemented within a concierge care model, these post-treatment lifestyle enhancements help bridge the gap between intervention and integration. They transform the home and body into environments conducive to healing, sustaining not only the cellular regeneration achieved during intensive treatment but also the erotic re-patterning fostered by somatic and psychosexual therapies.

7.2. Adjunctive Entheogenic and Somatic Approaches in Psychosexual Healing

The term *entheogen*, derived from the Greek *entheos*—“the divine within”—refers to substances or practices that facilitate access to heightened states of inner awareness, emotional catharsis, and somatic insight. In therapeutic contexts, entheogenic modalities include both exogenous compounds such as psilocybin, ketamine, and ayahuasca. Endogenous techniques include breathwork and mantra practices, including japa—the repetitive chanting of a sacred sound or phrase to facilitate altered states of consciousness, emotional regulation, and neurophysiological coherence. Transcendental Meditation, mindfulness-based stress reduction (MBSR), and japa practices have been shown to reduce stress, enhance self-awareness, and promote neurophysiological coherence, with measurable effects on the autonomic nervous system, immune modulation, and emotional regulation [96]-[101]. These tools are not considered standalone treatments but are emerging as powerful adjuncts that support trauma resolution, neuroplasticity, and overall sexual wellness when used ethically under qualified guidance and supervision.

At low, sub-perceptual doses, a practice known as *microdosing*, substances such as psilocybin have shown promise in modulating mood, reducing anxiety, enhancing emotional resilience, and disrupting maladaptive cognitive patterns without producing full psychedelic effects [102]. When integrated into a broader psychosexual protocol, microdosing may enhance participants’ capacity for self-regulation, erotic attunement, and interpersonal connection, particularly when navigating trauma-based inhibition or shame.

By contrast, higher doses—ranging from therapeutic to heroic levels—are intended to induce full-spectrum psychedelic states that can catalyze profound transformations in consciousness, identity, and emotional integration. In legal clinical trials and ceremonial settings, these higher doses have been associated with intense yet potentially healing psychological experiences, including the revisiting of unresolved trauma, dissolution of egoic defense structures, and emergence of transpersonal insight [103] [104]. In relation to sexual healing, these high-dose journeys may help recontextualize deeply embedded patterns of sexual shame, abuse, or disconnection, restoring erotic vitality as a life-affirming force.

Ketamine-assisted psychotherapy, which occupies a unique regulatory and clinical space due to its approved medical use, has demonstrated rapid-acting antidepressant effects, increased neuroplasticity, and therapeutic breakthroughs in individuals with trauma-linked sexual dysfunction, including PTSD, depression, and emotional numbness [105] [106]. Similarly, ayahuasca—a psychoactive Amazonian brew containing N,N-dimethyltryptamine (DMT) and monoamine oxidase inhibitors—has been linked to deep somatic-emotional processing, catharsis, and post-traumatic growth when administered in ceremonial or clinical settings by trained facilitators [107].

Beyond pharmacologic approaches, breathwork is often termed the “endoge-

nous entheogen” due to its ability to induce altered states of consciousness through non-ordinary respiratory patterns. Techniques such as holotropic breathwork have been shown to stimulate the release of endogenous DMT, modulate serotonin and dopamine pathways, and access unconscious emotional material through somatic channels [108] [109]. When integrated into sexual wellness programs, breathwork enhances vagal tone, interoceptive awareness, and affect regulation—core foundations of embodied eroticism and trauma healing. It is essential to underscore that all entheogenic and somatic interventions must be administered only under the direction of qualified professionals, in full compliance with local laws, ethical safeguards, and trauma-informed protocols. These modalities are not recreational or universally appropriate, but rather case-specific tools within a broader interdisciplinary model that includes psychosexual therapy, regenerative medicine, and relational education.

When synergistically integrated with embodied methods such as the *Penetration Protocol*, and supported by regenerative therapies, and neuromodulation, these entheogenic tools can facilitate profound and multidimensional healing. These practices promote erotic individuation, trauma resolution, and nervous system coherence, supporting a trajectory toward sensual self-actualization—that is, the fullest expression of one’s erotic, relational, and embodied potential.

7.3. Erotic Vitality and Self-Actualization: A Transpersonal and Empirical Framework for Sexual Wellness

Sexuality, when approached holistically, extends beyond mere performance or the alleviation of dysfunction. Informed by humanistic and transpersonal psychology, this model recognizes erotic vitality as a dimension of human potential closely linked to psychological integration, relational depth, and physical well-being. This perspective draws on the foundational work of Abraham Maslow and Carl Rogers, who emphasized self-actualization—the realization of one’s fullest potential—as the ultimate aim of human development [110] [111].

Empirical evidence supports the premise that optimal sexual experiences can catalyze profound states of connection, transformation, and personal growth. Kleinplatz and colleagues (2009) identified components of “optimal sexuality”, such as deep connection, authenticity, and heightened sensory awareness, through qualitative interviews with individuals reporting exceptional sexual experiences [112]. Similarly, Jenny Wade’s research into transcendent sex documents how naturally occurring sexual experiences can elicit altered states akin to those reported during meditation or entheogenic journeys, suggesting that profound erotic states may engage universal neurophysiological patterns of human consciousness [113] [114].

Neuroscientific studies further elucidate the physiological underpinnings of such experiences. Georgiadis and Kringelbach (2012) demonstrated that sexual activity activates brain regions associated with reward, emotion, and self-referential processing [115]. These findings align with the understanding that healthy,

embodied erotic experiences can promote neurophysiological coherence and psychosocial flourishing.

The Penetration Protocol, grounded in the Embodied Psychosexual Method (EPSM) and Enactive Sexual Method (ESM), operationalizes these insights through structured practices such as genital mapping, suction-based hip coordination, embodied consent, and arousal-aware breathwork. These interventions aim to restore somatic awareness, enhance relational attunement, and foster autonomous sexual agency. Early evidence from somatic sexology and trauma-informed practices suggests that such methods can promote emotional regulation, neuroendocrine balance, and sustained intimacy.

Importantly, this model is not presented as a substitute for empirical outcomes but rather as an integrative framework: one that recognizes both measurable improvements in sexual satisfaction, orgasmic function, emotional intimacy, and penetration quality—as observed in the current study—and the broader developmental potential sexuality holds when engaged with consciousness and intention. This approach may cultivate pleasure-centered hormonal rhythms—distinct from purely reproductive endocrine cycles—thereby offering a more expansive, resilience-based framework for optimizing sexual vitality, emotional well-being, and neuroendocrine regulation.

In a concierge medical framework, psychosexual education is further enhanced by regenerative interventions (e.g., EBOO, NAD⁺ infusions, PRP) that restore mitochondrial health, vascular integrity, and hormonal resilience, forming a comprehensive, biopsychosocial model for sexual optimization. This approach is both therapeutic and developmental: addressing dysfunction while facilitating self-efficacy, relational healing, and lifelong erotic flourishing.

Ultimately, while transpersonal frameworks provide inspirational context, the outcomes measured here remain rooted in observable psychosexual function, relational connection, and emotional vitality. Future research should continue to differentiate empirically validated psychosexual gains from transpersonal experiences, while exploring how expanded erotic states may contribute to broader psychosocial integration and well-being.

8. Conclusions

This study affirms the feasibility and preliminary efficacy of the Penetration Protocol in enhancing penetrative sexual fulfillment. As a novel integration of the Embodied Psychosexual Method (EPSM) and the Enactive Sexual Method (ESM), the protocol demonstrates potential as a scalable, clinically relevant intervention for psychosexual optimization.

Future research should prioritize replication in larger, more diverse cohorts across geographic and cultural contexts. Incorporating randomized controlled trials will strengthen the evidence base and enable comparative evaluation against other psychosexual therapies. Beyond validation, the multidimensional structure of the EPSM-ESM synthesis invites the development of targeted protocols for spe-

cific sexual dysfunctions, including vaginismus, anorgasmia, erectile dysfunction, premature ejaculation, and trauma-linked penetration anxiety.

Notably, early pilot studies have documented somatic improvements in vulvo-vaginal tissue integrity following EPSM-based interventions, reinforcing the bidirectional interplay between psychosexual practices and physiological change.

A particularly promising frontier lies in formalizing collaboration between regenerative medicine and somatic sexology. Integrating regenerative modalities—such as oxygen-based therapies, intravenous cellular support (e.g., NAD⁺ infusions), and laser-activated photobiomodulation with autologous platelet-rich plasma (PRP)—with EPSM/ESM-informed psychosexual therapy offers a compelling, synergistic approach to cellular rejuvenation and erotic restoration. Preliminary case series suggest that this synergistic model may enhance not only sexual function but also psychological resilience and relational satisfaction.

As additional case studies emerge, data-driven refinements will enable the personalization of these protocols based on variables such as age, trauma history, hormonal profile, and relational dynamics. This iterative evolution will ultimately yield a portfolio of precision protocols tailored to the psychophysiological uniqueness of each individual.

Moreover, the interdisciplinary concierge model introduced here represents a paradigm shift in integrative sexual healthcare. Plans are underway to disseminate findings through continuing medical education (CME) forums, fostering cross-pollination among practitioners in sexual medicine, psychology, urology, gynecology, integrative health, and somatic therapy.

In sum, this ever-evolving body of work represents not merely a therapeutic modality but a prototype for a novel genre of transdisciplinary, somatically informed sexual medicine. It synthesizes embodied awareness, regenerative science, and relational depth to reconceptualize human intimacy and psychosexual healing. In doing so, it advances a paradigm of sensual self-actualization and introduces the concept of *liberationship*—a consciously cultivated, liberatory model of intimate relating grounded in authenticity, love, growth, and innate somatic intelligence.

Conflict of Interest Statement

The first author Dr. Stefan Kasian serves as Director of a Private Membership Association providing regenerative services and resources, such as those mentioned in this publication. He did not receive any compensation for publishing this study.

Dr. Saida Désilets and Aaron Michael, co-developers of the therapeutic protocol, received compensation for its creation and hold advisor equities in affiliated ventures. To ensure objectivity, the feasibility study was monitored by an independent third party, Mr. Joseph Peill, who supervised data collection and participant interactions.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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Appendix A

Penetration Protocol Lessons 1-33 in Written Format

- 1) Lesson 1—Journaling to Enhance a Healthy Erotic Mindset
- 2) Lesson 2—Journaling to Enhance a Healthy Body Orientation
- 3) Lesson 3—Journaling to Support Healthy Relational Dynamics
- 4) Lesson 4—Heart/Genital Meditation
- 5) Lesson 5—Nervous System Wellbeing Meditation
- 6) Lesson 6—Combined Journaling & Meditation Practice for Handling Blocks to Arousal and Penetration
- 7) Lesson 7—Journaling to Diminish Fears and Self-Sabotage
- 8) Lesson 8—Self-Soothing Exercises
- 9) Lesson 9—Body Love Meditation
- 10) Lesson 10—Sexual Confidence: Heart/Belly/Genital Meditation
- 11) Lesson 11—Vase Breath—Front Body Relaxation Meditation
- 12) Lesson 12—Erotic Confidence (Journaling)
- 13) Lesson 13—Noticing Arousal Cues
- 14) Lesson 14—Transforming Penetration Anxiety
- 15) Lesson 15—Connection, Consent, & Asking Permission
- 16) Lesson 16—Skill Learning Pelvic Floor Breathing
- 17) Lesson 17—Pelvic Floor Breathing (Solo Practice)
- 18) Lesson 18—Pelvic Floor Breathing (Partnered Practice)
- 19) Lesson 19—Heart Genital Meditation
- 20) Lesson 20—Skill Learning Embodied Consent
- 21) Lesson 21—The Hug Game
- 22) Lesson 22—The Sensual Touch Game
- 23) Lesson 23—Hip Coordination Skill Learning
- 24) Lesson 24—Hip Coordination Game
- 25) Lesson 25—Pelvic Floor Sucking and Angling for Entry Skill Learning (Finger, Dildo, Penis to Anus or Vagina)
- 26) Lesson 26—Pelvic Floor Sucking and Angling for Entry Practice (Finger, dildo, Penis to Anus or Vagina)
- 27) Lesson 27—Managing Weight for Movement Skill Learning
- 28) Lesson 28—Grinding with Clothes on Practice
- 29) Lesson 29—Thrust and Reverse Thrust Skill Learning
- 30) Lesson 30—Signaling for What You Want Practice
- 31) Lesson 31—Anatomy as a System of Pleasure (Slide Show)
- 32) Lesson 32—Genital to Genital Erotic Mapping Solo Practice
- 33) Lesson 33—Genital to Genital Erotic Mapping Partnered Practice

Appendix B

Self-Report Assessment Instrument

Self-Report Assessment Instrument

Please reflect on your sex life with your current partner since you completed the program and answer the questions below:

1. Sexual Activity

The frequency of my sexual activity

0= No Sexual Activity	1= Not at all satisfied	2= A little satisfied	3= Moderately satisfied	4= Very satisfied	5= Extremely satisfied
☐	☐	☐	☐	☐	☐

2. Intimacy

Over the past 4 weeks, how satisfied have you been with the amount of emotional closeness during sexual activity between you and your partner?

- ☐ 0= No sexual activity
- ☐ 1= Very dissatisfied
- ☐ 2= Moderately dissatisfied
- ☐ 3= About equally satisfied and dissatisfied
- ☐ 4= Moderately satisfied
- ☐ 5= Very satisfied

3. Sexual Satisfaction

How would you rate your experience of sex at this moment in your life?

-7 = horrible, worst sex of all 0 = average sex +7 = transcendent, best sex of all time

-7	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6	7
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4. Sexual Activity Duration

What is your average length of a sexual activity (intercourse, caressing, foreplay & masturbation)?

- ☐ Less than 5 minutes
- ☐ 5 to 15 minutes
- ☐ 15 to 30 minutes
- ☐ 30 to 45 minutes
- ☐ 45 minutes to 1 hour
- ☐ More than 1 hour

Varied and unpredictable

5. Penetration Duration (Length of Time)

What is your average length of sexual intercourse (defined as sexual penetration vaginally or anally)?

- ☐ Less than 5 minutes
- ☐ 5 to 15 minutes
- ☐ 15 to 30 minutes
- ☐ 30 to 45 minutes
- ☐ 45 minutes to 1 hour
- ☐ More than 1 hour

Varied and unpredictable

6. Sexual Shame

Rate how much you agree with the following sentence:

It is difficult for me to fully enjoy sexual experiences due to shame.

- ☐ 0= Not applicable / no sexual activity
- ☐ 1= Almost never or never
- ☐ 2= A few times (less than half the time)
- ☐ 3= Sometimes (about half the time)
- ☐ 4= Most times (more than half the time)
- ☐ 5= Almost always or always

7. Sexual Monotony

Do you feel that your sexual experiences have become routine or predictable?

- ☐ 0= Not applicable / no sexual activity
- ☐ 1= Almost never or never
- ☐ 2= A few times (less than half the time)
- ☐ 3= Sometimes (about half the time)
- ☐ 4= Most times (more than half the time)
- ☐ 5= Almost always or always

8. Sexual Confidence

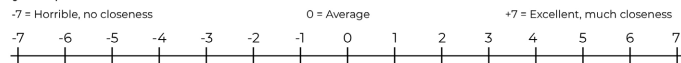
Rate how much you agree with the following sentence:

I have confidence in myself as a sexual partner.

- ☐ 1= Almost never or never
- ☐ 2= A few times (less than half the time)
- ☐ 3= Sometimes (about half the time)
- ☐ 4= Most times (more than half the time)
- ☐ 5= Almost always or always

9. Sexual Closeness Before Sex

Before having sex how would you rank your sense of emotional closeness with your partner?

**10. Sexual Closeness After Sex**

After having sex how would you rank your sense of emotional closeness with your partner?

