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Sex Coaching for Non-Sexologist Physicians: How to Use the Sexual Tipping Point Model

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INTRODUCTION

This commentary encourages a transdisciplinary perspective and offers guidance on using the Sexual Tipping Point (STP) model as a framework for integrating sexual counseling with other medical treatments physicians believe are appropriate when evaluating and treating male and female sexual dysfunctions (SDs).[1] Although this commentary is directed toward physicians, per the invitation of the *Journal of Sexual Medicine*'s Editor-in-Chief, many non-physician healthcare professionals have found the STP model a useful framework for their own clinical practices.

The *Journal of Sexual Medicine* invitation to submit this commentary was timely. It marks the 15th anniversary of the earliest publication recommending sexual coaching for men and their partners, and the 15th anniversary of the lecture introducing the STP model for the understanding of female and male sexual dysfunctions.[2] The first STP lecture copyright was granted in 2001 by the U.S. Copyright and Patent Office for Perelman's Columbia Medical continuing medical education invited presentation recommending the STP model as a theory to understand female sexual disorders as well as male SD. Since 2012, the MAP Education & Research Foundation [a 501(c)(3) public charity] now owns all STP copyrights. The Foundation's website offers (mapedfund.org) free download of all STP publications and presentations to any student or professional upon request.

This commentary updates the original concepts and also updates the STP cartoons that the *Journal of Sexual Medicine* published in 2009 to the current variable-control switch model imagery.[3,4] The STP model illustrates both the intra- and interindividual variability characterizing sexual response and its disorders for both men and women. The STP model offers a structure for conceptualizing relevant micro/macro mind and body etiologic variables (subjective or objective) and a pathway for treatment and follow-up. Guidance is provided to physicians on integrating this updated STP model when counseling patients to optimize understanding and outcome. Such integration becomes especially important when treating complex SD cases. The STP facilitates the development of a biomedical and psychosocial-cultural narrative to explain multidimensional etiology and a rationale for specific treatment targets.[3] Perhaps the model's greatest advantage is its simplicity, providing clinicians with a common-sense explanation of sexual problems and potential solutions for men, women, and their partners.

THE SEXUAL TIPPING POINT MODEL

The STP, while recognized by a growing number of sexual medicine specialists, is only one of a number of biopsychosocial models available to comprehend sexual function and dysfunction.[3,5–13] Biopsychosocial models, as noted by Rullo et al,[12] are "considered the gold standard because … sexual dysfunctions involve a complex interplay of biological, psychological, interpersonal, and sociocultural factors … the foundation for clinical theories and paradigms including the sexual tipping point, the dual-control model, and systemic sex therapy." The current evidence supporting the STP model's versatility as a clinical and teaching heuristic is limited to expert opinion.[4] For those interested in works citing the STP model, a list is available at http://www.mapedfund.org in the Menu under STP Resources. The STP can guide thinking about etiology, diagnosis, treatment, and follow-up. Originally identified as another binary dual-control model, it has morphed into a variable-control model reflecting advances in our biological, psychosocial, and technological knowledge about the human body.[4,7] The STP model illustrates, and can help explain in great detail, the complex factors intrinsic to all aspects of a woman's or man's sexual response.[3] The hypotheses and key elements underlying the STP model are summarized below and illustrated in Figure 1.

Two pans labeled "Excitation" and "Inhibition," respectively, hold 2 pairs of interconnected containers. The containers are labeled M (Mental) and P (Physical) and are bridged together by an A (And), recognizing that the line between mental and physical has become progressively more porous with greater understanding of how thoughts become translated into biochemical/electrical components. There is cross-talk between all these pathways contributing to sexual response, which is presumed to be continuous and not categorical, dynamic and not static. Even when a dysfunction appears to be static, it is hypothesized that there are a range of multiple conflicting forces that may be dynamically maintaining it. The Mental containers include but are not limited to factors related to cognition, emotion, social/interpersonal, and culture. The Physical

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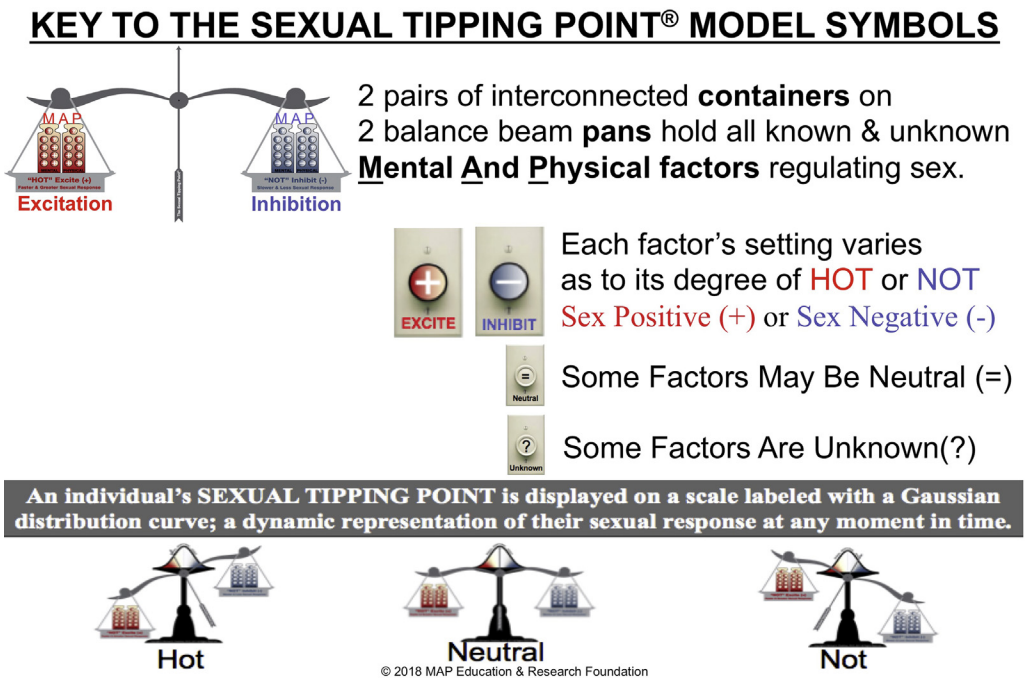

Figure 1. Circles inside the Mental And Physical containers represent dimmer switches, whose valence and polarity contribute to the Sexual Tipping Point. This image is based on the Sexual Tipping Point model and is used with the permission of the MAP Education & Research Foundation.

containers include but are not limited to factors related to anatomy, genetics, endocrinology, drugs, disease, surgery, and environment. For example, the Physical containers hold all known and unknown representations of neurotransmitters, including their various subtypes and receptor subtypes. Respectively, the Mental containers hold, among other factors, both the positive and negative impact of religion and other value systems on a person's sexual response. These Mental And Physical containers symbolically, then, hold all of the exciting (+) and inhibiting (−) factors that influence a sex-positive or sex-negative response. Each of these billions of factors (dimmer switches) are variably charged and with variable valence as to the degree they contribute to the STP. Some of these factors may also be neutral (=), while again, others have not yet been discovered (?). The STP, then, is the net sum of all Mental and Physical factors, displayed on a balance scale, labeled with a Gaussian distribution curve that spans from excitation to inhibition. Therefore, each factor's dimmer switch setting contributes to the STP's dynamic representation of any individual's manifest sexual response at any moment in time. Individualized attention needs to be paid to a specific patient's critical factors, as unique (sometimes counterintuitive) combinations can cause significant and meaningful SD. A common example, for instance, would be a woman with low desire who is still capable of arousal and orgasm, or, reciprocally, a woman with strong desire who is unable to experience arousal or orgasm. The primary reasons for such disparity become the treatment targets. Once they have a multifactorial understanding of the forces that created/maintain the SD, clinicians can inspire hope by explaining the STP formulation and more easily describe the initial treatment process to the patient and partner.

SEX COACHING: THE SEX STATUS AND COMMON CAUSES OF SD

Why is sex coaching even needed? It is a truism that every SD (regardless of the severity of its organic etiology) also has a psychosocial component that, if not causative, is certainly consequential. Regardless of the degree of organic etiology, SD is exacerbated by insufficient stimulation: an inadequate combination of subjective erotic thoughts, feelings, and the physical stimulation needed by a given individual to experience a desired sexual response. All healthcare professionals (HCPs) need to appreciate both how psychosocial-cultural factors can cause SD and how that knowledge can help improve compliance with the HCP's prescriptions and recommendations, resulting in increased patient and HCP satisfaction.[2]

The most important diagnostic tool we have in understanding behavior is a clear and detailed description. The sex status exam, a specific type of focused sex history-taking, is key to the sex coaching process.[2] Communication issues (sexual and otherwise) between the partners themselves (and with their healthcare providers) can cause, exacerbate, or interfere with the resolution of sexual difficulties.[14,15] People often fail to communicate their preferences to either their partners or HCPs, because of embarrassment. HCPs need to become "sex detectives," whose detailed questions about the patient's sexual status unveil the causes of dysfunction and noncompliance. Inquire directly about desire,

fantasy, frequency of sex, as well as the effects of drugs and alcohol. Did arousal vary during manual, oral, and coital stimulation? A sex status exam is not a lab test or a questionnaire. It is a detailed focused diagnostic interview that examines all aspects of current sexual functioning in combination with potentially germane historical experiences.[2,16]

The STP can serve as a framework that guides the relevant questions. A detailed description of the patient's current sexual experience and the couple's erotic interactions will help rule out physical causes and help identify antecedents and/or maintainers of the disorder. "Tell me about your last sexual experience," is a good question to expedite that process. During training, clinicians regularly learn that active listening and the use of open-ended questions are critical history-taking tools.[17] However, balancing the "time crunch" will necessitate closed-ended questions as well, to narrow down the key targets for treatment.[2] A good sexual status exam creates a video picture in an HCP's mind about the friction, frequency, fantasy, and feelings (mnemonically, "4 Fs") the patient is experiencing, by identifying the factors that precipitate and maintain the patient's chief complaints. Fantasy refers to all erotic thoughts and feelings that are associated with a given sexual experience. High-frequency negative thoughts (and associated negative emotions) can neutralize or override erotic cognitions (fantasy) and subsequently delay, ameliorate, or completely inhibit sexual response; and inadequate partner stimulation (friction) may result in an unsatisfying experience.

The difference between what the patient experiences in coupled sex, versus self-stimulation, must be explored to the extent both the HCP and/or the patient can do so without extreme discomfort. Too great a disparity between the reality of sex with their partner and their preferred sexual fantasy (whether or not unconventional) is sometimes identified during inquiry about masturbation.[18] Whenever possible, inquiry into masturbation style, technique, and frequency should be conducted for almost all patients presenting with sexual issues. Idiosyncratic masturbatory patterns are a frequent hidden cause of SD for both men and women. Assessment must include attention to the patient's degree of immersion and focus on arousing thoughts and sensations during masturbation, compared with partnered sexual activity. This often requires exploration of sexual fantasies, as well as examining the patient's use of erotica and pornography. Identify the proportion of sexy versus anti-erotic intrusive thoughts like, "It's taking too long," which can apply to both women and men; for both similar and different reasons. Is this partner just insensitively complaining, "she takes too long" and requires too much foreplay? Or is a genuine arousal difficulty being correctly identified? Is a complaint that he takes too long to orgasm during intercourse reflecting a dislike of sex? Or is his partner suffering secondary to a diagnosable delayed ejaculation SD? All require exploration, and the opportunity to educate begins during the evaluation visit as appropriate. Asking about the patient's thoughts during sex also reveals when religious and cultural values are currently inhibiting sexual response. At some point, the patient might balk at these personal and intrusive questions, but once the patient is assured that research has shown such information is critical to successful outcome, refusal to engage in such inquiry is rare in this author's experience.[2,15,18]

Additional questions will identify other etiologic factors that improve or worsen sexual function, (particularly psychosexual arousal). Along with the current situation, the clinician will review life events/circumstances temporally related to changes in sexual status. Previous treatment approaches would be explored, including the use of herbal therapies, home remedies, among others, and if any benefit was obtained.[2,16] Before the evaluation concludes, the patient can be offered an STP formulation that highlights both the immediate cause of the problem and how it might be alleviated.

PARTNER ISSUES

Relationship factors are common causes of SD and include but are not limited to power struggles, intimacy blocks, poor communication, and inadequate conflict resolution skills. Physicians often do not have time to explore these in depth, but they are important to note, as regaining sexual capacity does not necessarily translate into the couple resuming sexual intercourse. Psychological issues may render the best treatments ineffective.[2,14] As a recent sexual experience is explored in depth, the patient is likely to implicitly or explicitly indicate the relevance of partner issues. Look for implicit or explicit expressions of either anger or hurt feelings, which are often antithetical to good sex. However, significant partner issues are beyond sex coaching and usually require referral. Successful treatment typically requires a supportive available sexual partner, but be sensitive to patient preference regarding partner participation, as patient and partner cooperation is more critical to successful treatment than partner attendance at office visits. Although conjoint consultation is a good policy, it is not always the right choice. Obtaining information from the partner is often helpful (when possible), but it is partner support and cooperation independent of actual attendance during office visits that is critical.[2]

TREATMENT

Treatment in the form of patient education should be initiated immediately during the office visit and be integrated into the history-taking process to the extent it does not interfere with rapport building or obtaining the necessary information. Using the STP model can help the patient understand the need to be immersed in excitation (+) and minimize inhibiting thoughts (−) to experience each aspect of sexual response in his or her preferred manner. Discussion of a potential biologic predisposition is useful in reducing patient and partner anxiety and mutual recriminations, while improving therapeutic alliance.[1]

Many physicians, for better and sometimes for worse, will begin treatment by first prescribing pharmaceuticals, lubricants, and devices, but all should be supplemented with sex coaching. Concepts such as selfishness may require reframing. Both men and women often need encouragement to focus more on their own pleasure, with somewhat less concentration on providing stimulation that is presumed to be best for the partner. Patients may need permission to supplement the reality of sex with their partner with the use of mindfulness and fantasy to increase desire and arousal.[19] Sometimes an auto-sexual orientation needs to be validated so that stigma is reduced. Patients may need encouragement to share their preferences, so that both their needs are met. A partner may experience some feelings of rejection and/or disconnection with such a discussion, but subsequent sexual fulfillment usually offsets such emotions. However, a sex therapy referral may be needed when feelings of jealousy or abandonment are extreme. Similarly, sometimes sexual fantasies require significant realignment, so that thoughts experienced during masturbation match better with those occurring during partnered sex.[1] Yet, meaningful disparity in partner sexual scripts (which are not integrated into either fantasy or reality within partnered sex) often reflect more severe problems (relational or otherwise). Such situations tend to result in treatment recalcitrance, and a sex therapy referral should be suggested.[18]

TIME CRUNCH

Time crunch can be managed, even if the patient avoids discussing the SD until the physician reaches for the door, or if earlier questions unleash a delayed torrent of information and emotion. There is no need to despair, as there are 4 steps available to effectively manage time crunch. 1) Show concern and listen for 1 minute to whatever the patient is saying without interrupting. 2) Emphasize the availability of help and probability of a successful outcome. 3) Sympathetically note the office visit's time limitation, while empathizing with the importance of the topic and the necessity for adequate evaluation. 4) Immediately facilitate scheduling of a new appointment (follow-up) to focus on the sex issue. In this manner, the schedule is maintained while the patient is reassured by both the physician's concern and the availability of forthcoming help.

FOLLOW-UP AND THERAPEUTIC PROBE

When initiating treatment, simultaneously schedule a follow-up visit, as initial failures examined at follow-up will reveal critical information. Every intervention, recommendation, and prescription acts as a therapeutic probe, which can illuminate the causes of failure or non-response. Retaking a quick sex status with the STP model in mind provides a convenient model for follow-up.[2] Components of the follow-up visit include more than monitoring side effects. There are numerous physical issues to consider that evoke noncompliance concerns beyond whether an alteration in medication is needed, including but not limited to both male and female reactions to change associated with aging (eg, menopause often presents challenges for both partners); reactions to chronic diseases or injury; and smoking, alcohol, and recreational drug use. Important psychosocial issues must also be considered, including but not limited to changes associated with life stressors such as loss of partner, partner's attitude, and life-cycle issues. These factors and others described earlier can all contribute to inhibition of sexual function, and differentiating them will help enhance success rates.[2] Follow-up offers opportunity for turning early failures into success, as patients gain greater sexual confidence by reframing expectations and correcting misperceptions. For example, when a man using a PDE-5 reports initial medication "failure," discuss the possibility of masturbating with medication (when appropriate and if not already considered earlier) as a learning exercise. An anxious recently divorced man who is using condoms for the first time in years is usually better off experimenting with a condom during masturbation, then attempting sex with his partner when trying a new sex pharmaceutical. Similarly, a woman recovering from a sexual pain disorder (especially occurring during partnered sex) will probably need time to explore her sexual capacity independent of her partner unless her cultural/religious beliefs would prohibit such a suggestion.

Involve patients in treatment decisions whenever possible. Resistance and noncompliance are common during treatment for sexual problems of both sexes, and early failures can be reframed based on information obtained during follow-up sessions. Doing so improves the likelihood that instructions are followed and success obtained.[2]

WEANING AND RELAPSE PREVENTION

Especially when preferred by the patient, follow-up provides an opportunity for those being treated with drugs and/or using external devices to be weaned (reducing dose and/or use), thus providing an optimum risk/reward ratio.[2,20] When illness, medication side effects, stress, and so forth, change the STP balance for the worse, resuming sexual medication, devices, and/or counseling can helpfully be added back into the equation.[1]

REFERRAL

A successful evaluation will identify the primary factors currently determining a SD. Referral for adjunctive treatment to a sex therapist, gynecologist, urologist, neurologist, endocrinologist, physical therapist, among others, for the patient and/or partner may be required. Identifying psychosocial factors does not necessarily mean an initially consulted HCP should treat them. Sex coaching is designed to improve the probability of a successful treatment outcome and reduce the likelihood HCPs will need to refer out for sex therapy or couples' therapy. However, couples with severely problematic relationships, very unrealistic expectations, disguised or hidden arousal patterns (sexual orientation, etc) will definitely require appropriate

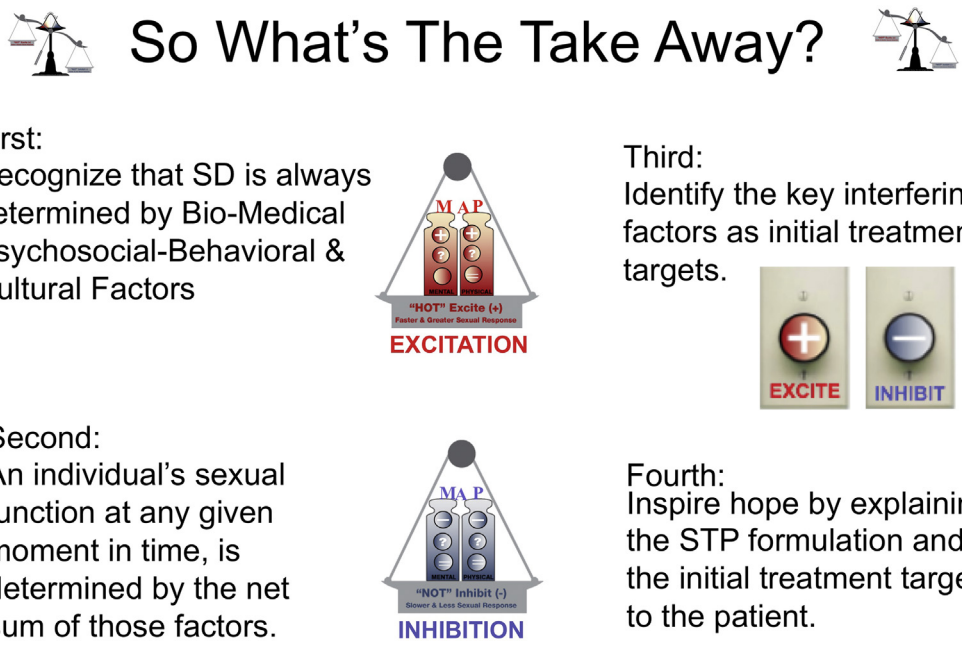

Figure 2. The Sexual Tipping Point variable-switch model approach to sexual dysfunction. This image is based on the Sexual Tipping Point model and is used with the permission of the MAP Education & Research Foundation.

adjunctive care.[2] Frequently, brief counseling by the HCP of the patient is sufficient. The more problematic the relationship or the more profound the couple's strife, the less likely that patient—partner sex education will be able to successfully manage treatment in and of itself. Inevitably, a referral would be required, albeit not necessarily accepted. When possible, the initial treating physician should obtain permission from the patient (as appropriate) to confirm whether or not the referral took place and the outcome. A response can then be offered, whether congratulations or further encouragement to pursue the referral and/or an alternate professional as required. This may provide additional motivation and encourage a resistant patient to seek needed assistance.

Finally, if not inclined to counsel, or if uncomfortable, the HCP should consider referring or working conjointly with a sex therapist or other mental health professionals as needed. Whether a referral is initiated by the HCP or patient, there are numerous mental health professionals ready to effectively assist in educating the patient about optimizing sexual response. As illustrated in Figure 2, the STP concepts fit within an integrative approach that appreciates multilayered causation and identifies treatment targets and risk/benefit for patients with SD, thus facilitating informed consent and genuine understanding.[1]

CONCLUSION

It is certainly important for HCPs to discuss sexual health with their patients and integrate sex coaching into routine office practice. Incorporating sex coaching will enhance the HCP's relationships with patients and increase the success in improving patients' sexual health. Although meeting with partners of patients may be desirable, there are alternative options for enhancing sexual functioning. The Internet abounds with sexual information, but most patients will benefit from it being filtered through their HCP's wisdom. There always will be new medical and surgical treatments/devices available to HCPs in the future, and integrating sex coaching will complement all of those approaches.

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Conflict of Interest: Michael A. Perelman is founder and chairman of the MAP Education and Research Foundation, a 501(c)(3) public charity devoted to the education of healthcare professionals.

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