

**HerDesire.net**

**The STP Model Helps Optimize  
The Diagnosis & Treatment Of HSDD**

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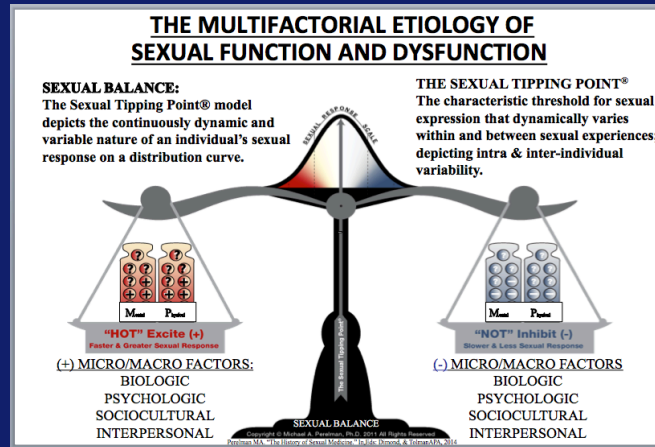
Weill Cornell Medicine

New York, NY, USA

# 2017 PERELMAN DISCLOSURES

Item	Company	Applies to	Financial	Relationship Type	Begin Date	End Date
1	AMAG	Self	Yes	Consultant or Advisor	01/02/2016	present
	Advisory board					
2	Springer Publications	Self	Yes	Health Publishing	10/01/2012	present
	Emeritus Editor in Chief of Current Sexual Health Reports					
3	Valeant	Self	Yes	Consultant or Advisor	02/20/2017	present
4	MAP Education and Research Fund	Self	No	Leadership Position	08/01/2012	present
	Founder and President of this 501(c)(3) public charity devoted to education of healthcare professionals.					
5	Palatin	Self	Yes	Consultant or Advisor, Investment Interest	02/02/2009	present

# STP Approach To Treating HSDD



## AGENDA

1. Describe and illustrate the Sexual Tipping Point® model's integrated approach to understanding the etiology, diagnosis and treatment of FSD in general and HSDD specifically.
2. Discuss taking a sex status and its use within a STP framework.
3. Discuss an HSDD case using a STP based sex therapy.

# The STP Model Helps Optimize The Diagnosis & Treatment Of FSD

Sex therapists distinguish ourselves by asking about sex in minute detail, while maintaining rapport with the patient.

**What guides my questions?**

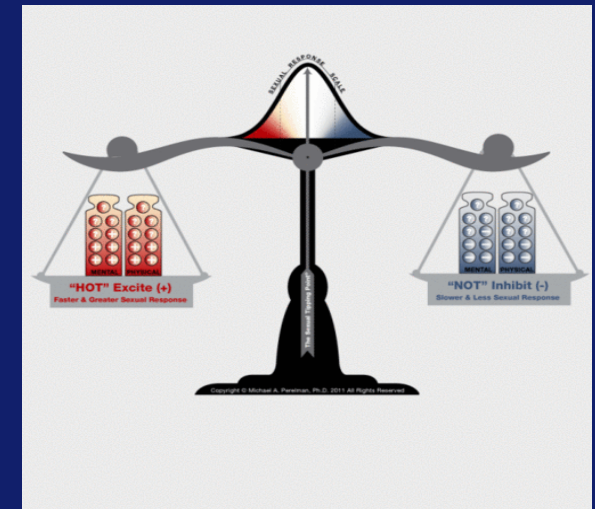


# The STP Model Helps Optimize The Diagnosis & Treatment Of FSD

**ANSWER:**

## The Sexual Tipping Point® Model

The STP is an easy way to depict both the mental and physical elements of FSD, facilitating an integrated treatment approach.



# The STP Model Helps Optimize The Diagnosis & Treatment Of FSD

ANSWER:

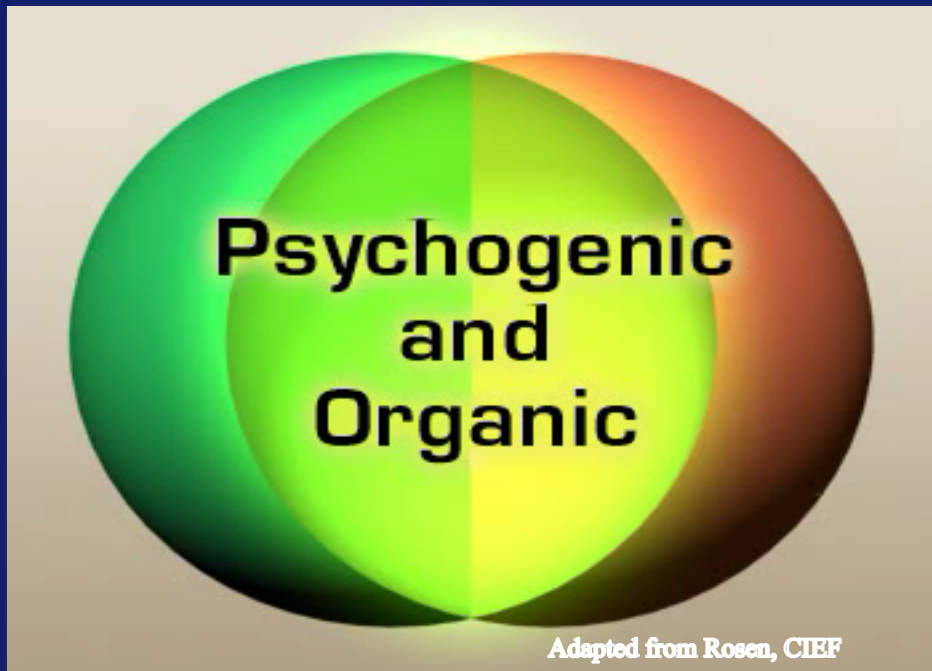
## The Sexual Tipping Point<sup>®</sup> Model

The STP is an easy way to depict both the mental and physical elements of female sexual function and dysfunction, facilitating an integrated treatment approach.



Perelman MA. *J Sex Med.* 2006; 3:1004-1012;  
Perelman MA. *J Sex Med.* 2009;6(3):629-32.

Because sexual response is best understood as an endpoint, representing the cumulative interaction of every cognitive, behavioral, social and cultural factor, not merely the biological determinants!



# Sex is Always Mental and Physical

The mind can "turn you on" and the mind can "turn you off."  
The body can "turn you on" and the body can "turn you off."  
Positive mental and physical factors increase sexual response.  
Negative mental and physical factors inhibit sexual response.

**The dynamic combination of all these factors  
determines a unique Sexual Tipping Point®**





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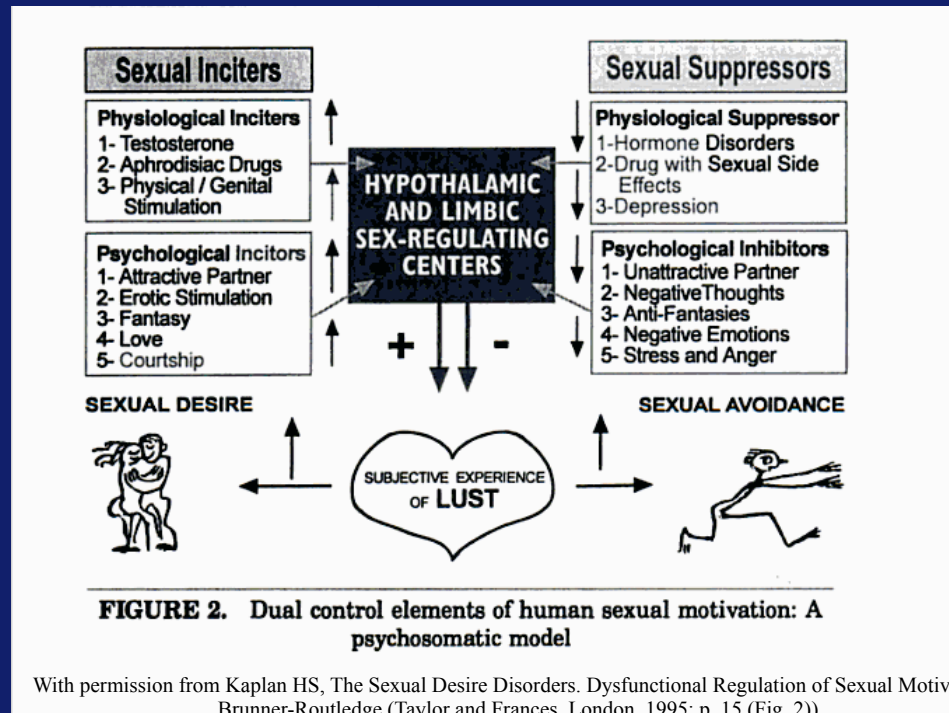
**The dynamic combination of all these factors determines a unique Sexual Tipping Point®**



# BIOPSYCHOSOCIAL DUAL CONTROL MODELS EASILY EXPLAIN SUCH INTERACTIONS

John Bancroft and his Kinsey colleagues skillfully articulated the most well known and researched dual control model, but Helen Kaplan was first to publish a dual control psychosomatic model of sexual motivation in 1995. An artist by training; her illustration is below.

Sexual Inciters



Sexual Suppressors

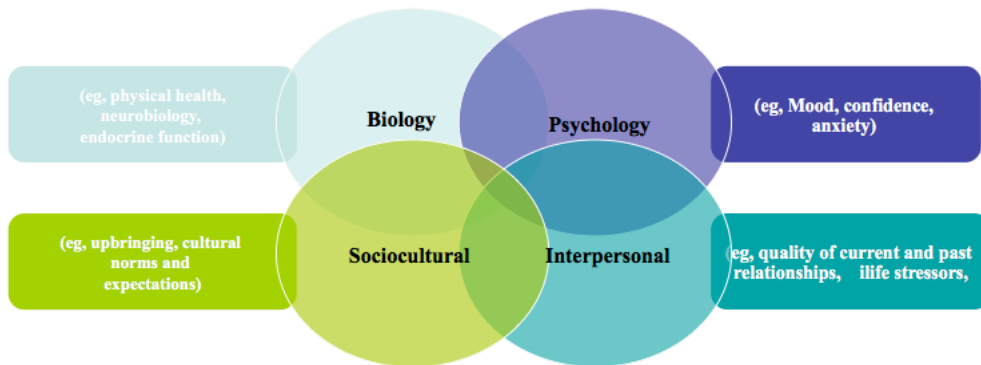
Bancroft et al, 2009

Perelman MA. "The History of Sexual Medicine"  
In Eds: Diamond, & Tolman, APA Handbook , 2014

# Of Course, There Are Numerous Sexual Response Models

Althof & Rosen illustrate their biopsychosocial model with a simple and elegant Venn diagram.

## Biopsychosocial Model of Female Sexual Response

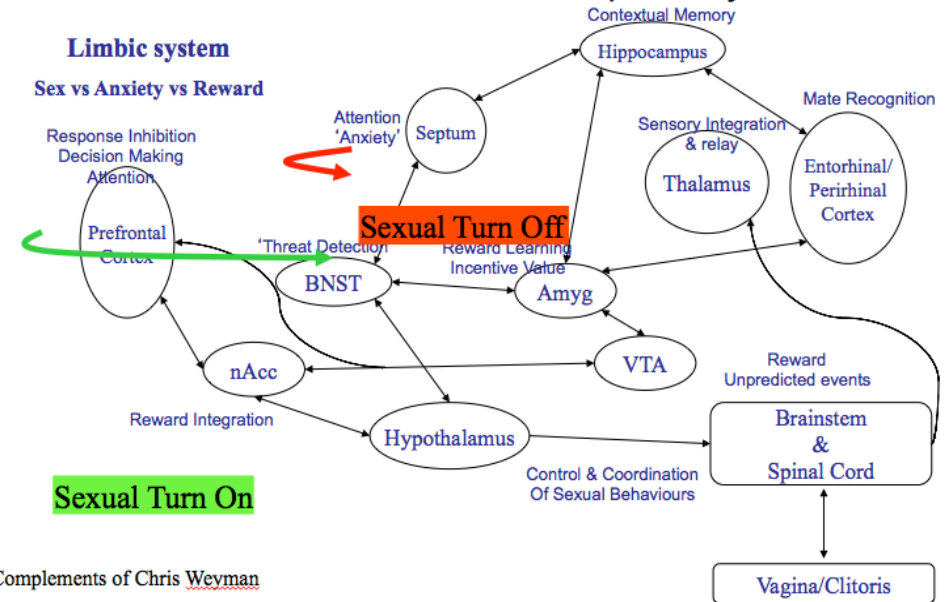


Althof SE, et al. *J Sex Med.* 2005;26:793-800. Rosen RC, Barseky JL. *Obstet Gynecol Clin North Am.* 2006;334:515-526.



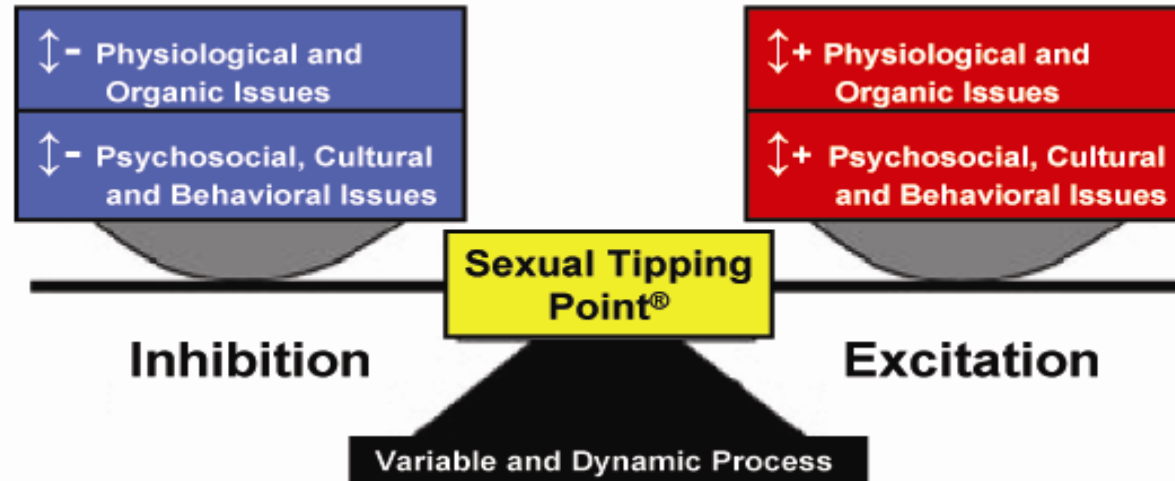
Chris Weyman has presented granular diagrams identifying on/off loci of biological pathways.

## Control of Female Sexual Function “Prosexual” versus “Antisexual pathways



# Jim Pfaus Used The STP Concept In His Classic 2009 JSM Article, On The Neurobiology Of Sexual Desire.

## Dual Control Model



after Perelman (2006) *J Sex Med*, 3, 1004-1012

Slide courtesy of Jim Pfaus

Pfaus, JSM, 2009

The model has universal applicability and the capacity to illustrate the full range of human sexual response, yet it can be distilled into a simple:

“Hot” or “Not” ?

**BUT FOR SOMETHING SIMPLE,  
IT CAN LOOK PRETTY COMPLICATED!**

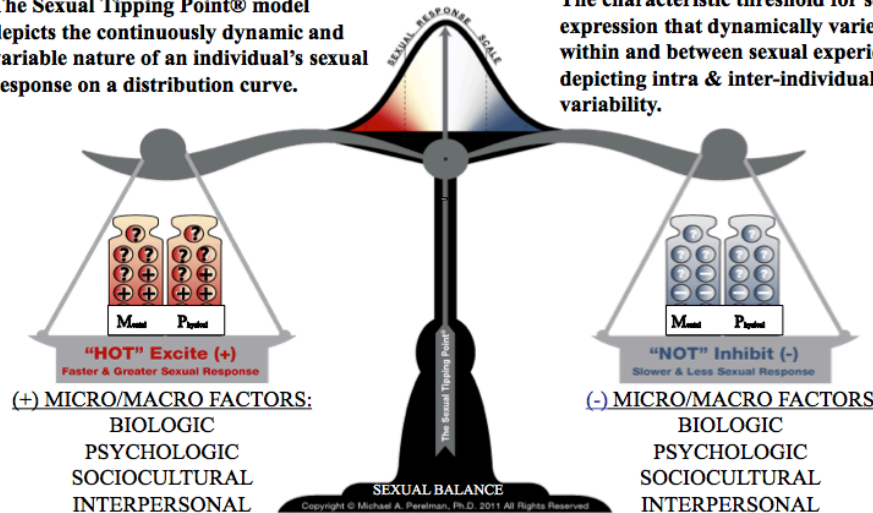
### THE MULTIFACTORIAL ETIOLOGY OF SEXUAL FUNCTION AND DYSFUNCTION

#### SEXUAL BALANCE:

The Sexual Tipping Point® model depicts the continuously dynamic and variable nature of an individual's sexual response on a distribution curve.

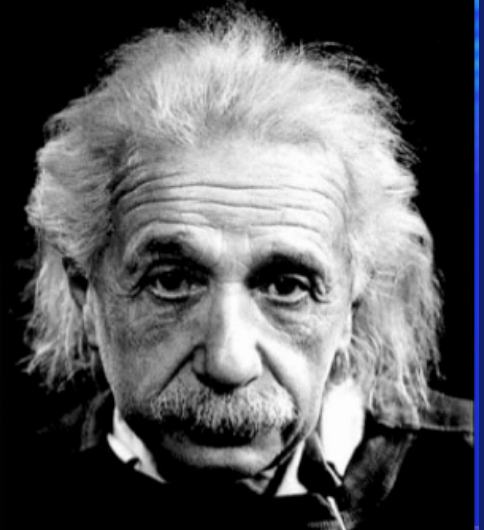
#### THE SEXUAL TIPPING POINT®

The characteristic threshold for sexual expression that dynamically varies within and between sexual experiences; depicting intra & inter-individual variability.



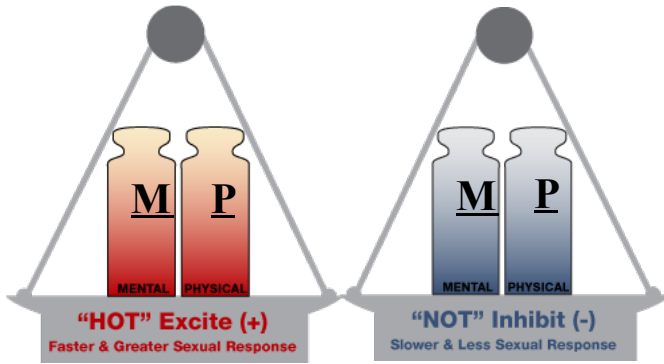
“Everything should be made as simple as possible, but not simpler.”

Albert Einstein



# LET'S BREAK IT DOWN

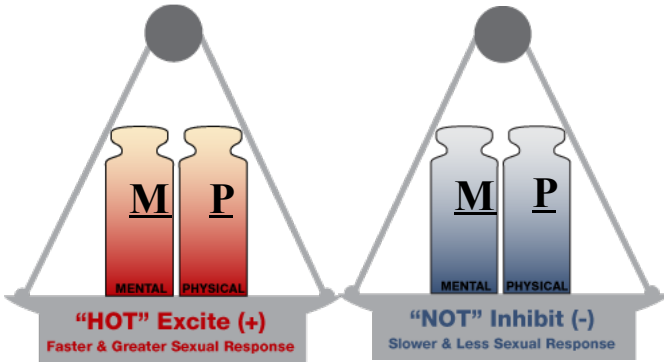
## KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS



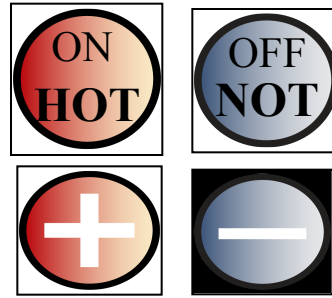
4 Containers on the scale, hold all known and unknown Mental & Physical factors regulating sexual response.



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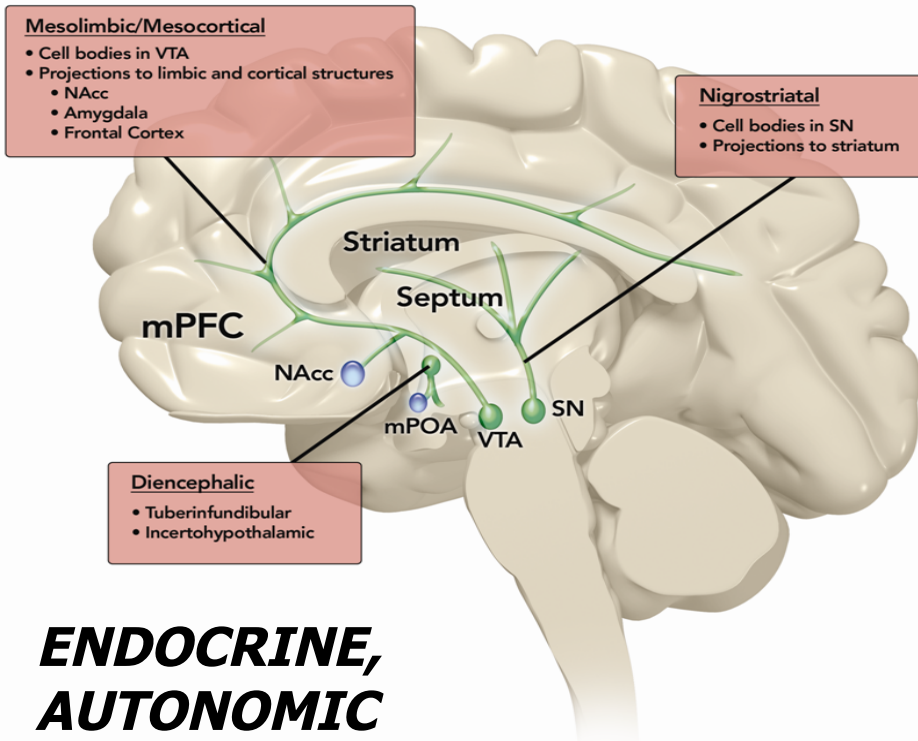
Each individual factor is ON/OFF,  
represented as: HOT or NOT

Sex Positive (+) or Sex Negative (-)

# Jim Pfaus Speaks About Excitatory Brain Systems :

+

## Dopamine (DA)

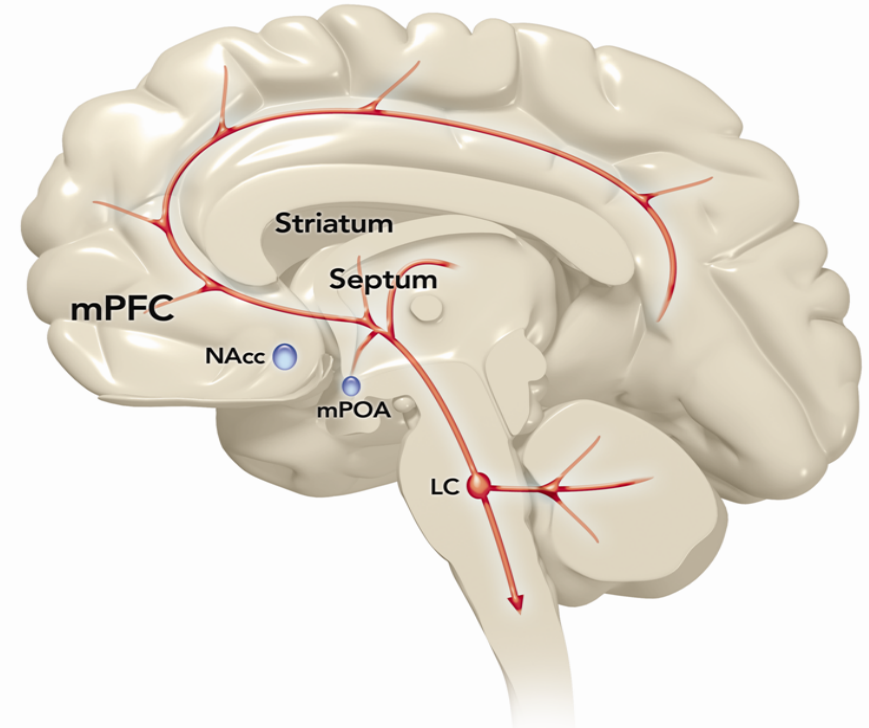


**ENDOCRINE,  
AUTONOMIC  
REGULATION**

**ATTENTION,  
MOVEMENT**

+

## Noradrenaline (NA)



Cell bodies in locus coeruleus  
Projections to hypothalamic, limbic, and  
cortical regions; descending projections to  
cerebellum and spinal cord.

**AROUSAL**

# Fantasy or Cognitions

## Positive Thoughts (+)

1. I feel attracted to the person.
2. I want to experience physical pleasure.
3. It feels good.
4. I want to show my affection for my partner.
5. I want to express my love
6. I feel sexually aroused and want the release.
7. I feel horny.
8. It's fun.
9. I am in love.
10. I love being swept up by the moment.
11. I wanted to please my partner.
12. I want the closeness/intimacy.
13. I want the pure pleasure.
14. I want an orgasm/orgasm
15. This is exciting,
16. I wanted to feel connected to the person.
17. The person's physical appearance turns me on.
18. Love this setting.
19. This person really desires me.
20. This person makes me feel sexy.

## Negative Thoughts -

### IMPACT OF FSD ON THE WOMAN



Complements of Eli Lilly

## RELATIONSHIP FACTORS

### Interpersonal dimension

- 'there is no such entity as an uninvolved partner in a relationship contending with any form of sexual inadequacy'<sup>1</sup>
- the non-sexual part of the relationship suffers and conflicts may arise<sup>2-6</sup>



Photograph of Masters and Johnson by Buzz Taylor, courtesy of St Louis Walk of Fame

<sup>1</sup>Masters WH and Johnson VE. Toronto; New York: Bantam Books; 1970; <sup>2</sup>Althof SE. Int J Impot Res 2002;14(Suppl 1):S99-S104; <sup>3</sup>Dunn ME. J Am Osteopath Assoc 2004;104(Suppl 4):S6-S10;

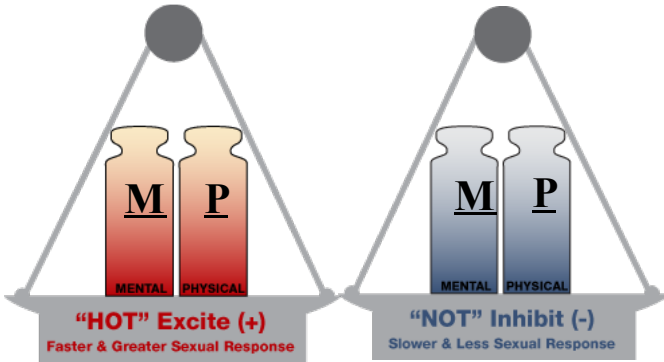
<sup>4</sup>Tomlinson J, Wright D. BMJ 2004;328:1037; <sup>5</sup>Dean J, et al. Eur Urol Suppl 2006;5:773-8

<sup>6</sup>Dunn, Althof, & Perelman, Int J Impot Res. 2007; 19:S99-S104

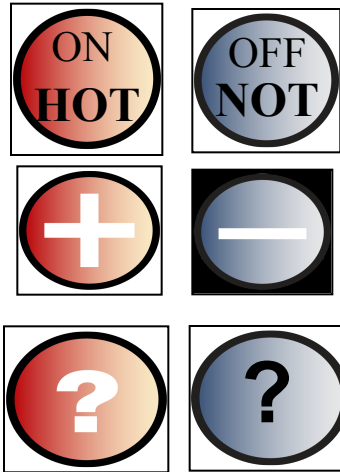
Meston, CM and DM Buss.

"Why Humans Have Sex," *Archives of Sexual Behavior* (2007) 36:477.

# KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS



4 Containers, hold all known and unknown  
Mental & Physical factors regulating sexual response.

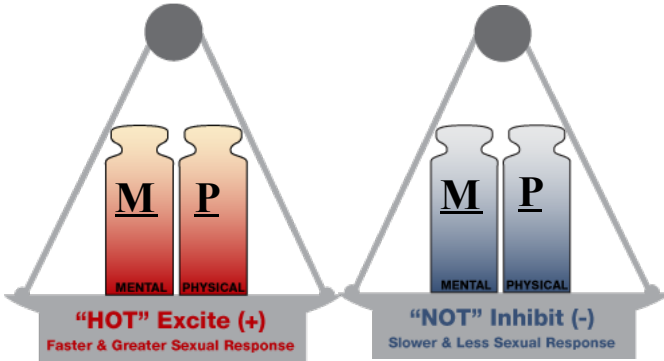


Each individual factor is ON/OFF,  
represented as: HOT or NOT

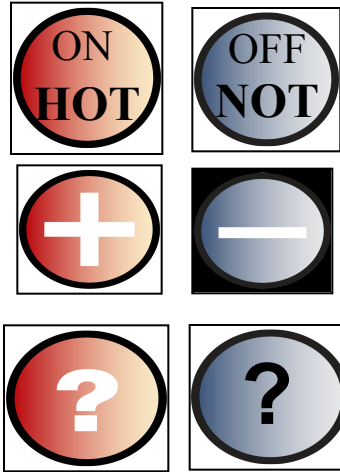
Sex Positive (+) or Sex Negative (-)

Unknown (?)

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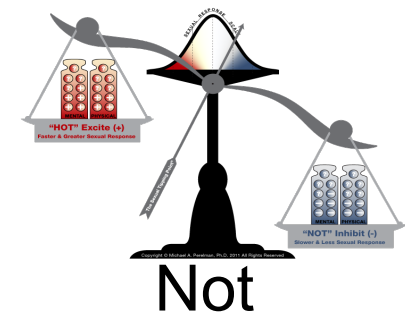
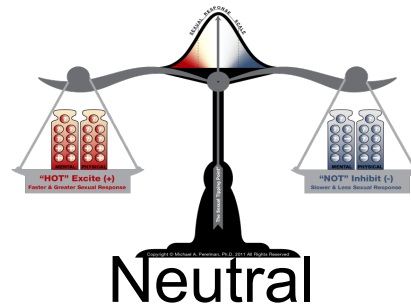
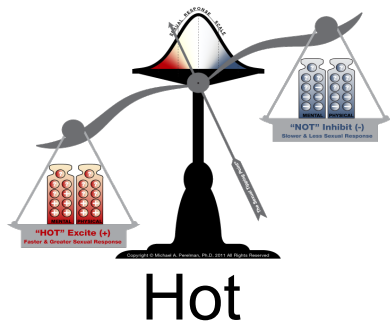


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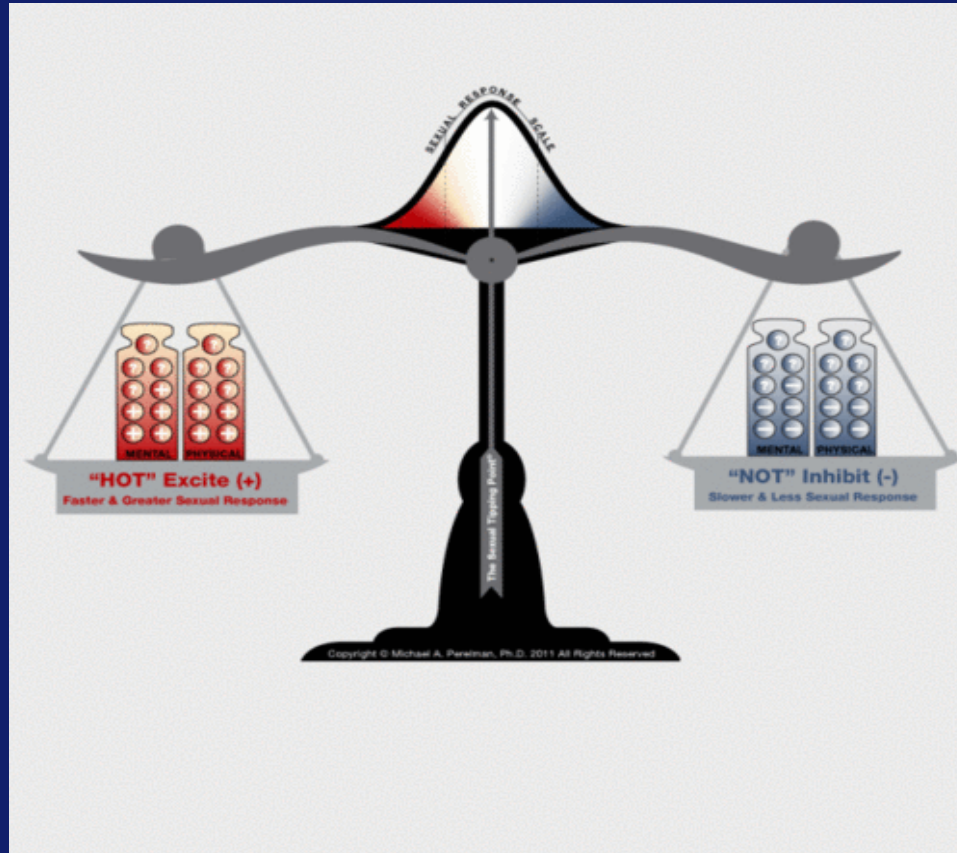
Unknown (?)

An individual's **SEXUAL TIPPING POINT** is displayed on a scale labeled with a Gaussian distribution curve; a dynamic representation of their sexual response at any moment in time.



The STP model dynamically illustrates both the intra and inter-individual variability characterizing sexual response and its disorders for both men and women. A person's STP differs from one experience to another, based on the proportional effect of dominating factors, as others recede in importance.

**“HOT”**



**“NOT”**



**“Cougar” or “Kitty Kat”?**

# STP Approach To Treating FSD

Based on their valence, you identify their impact on the patient and which of these mental or physical factors should be targeted for intervention and their impact :

- Predisposing ( constitutional, prior life experience)
- Precipitating, exacerbating and/or
- Maintaining a sexual dysfunction, disorder or concern.

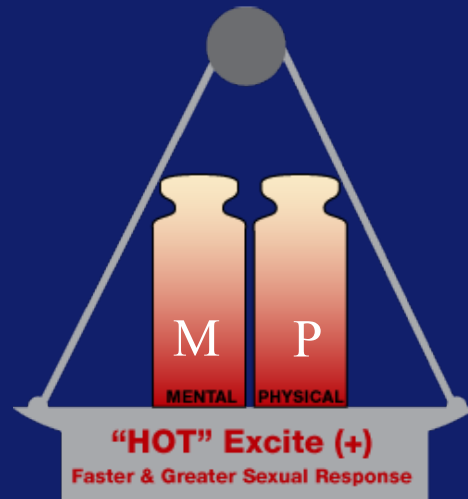
**SHE CAN EASILY UNDERSTAND AND GAIN HOPE  
AS YOU ALSO IDENTIFY A PATH TO RECOVERY!**

Althof et al, JSM, 2005; Althof et al, JSM, 2009;  
Basson R. JSMT. 2000;  
Hawton K. Br J Hosp Med 1985

# So What's The Initial Take Away?

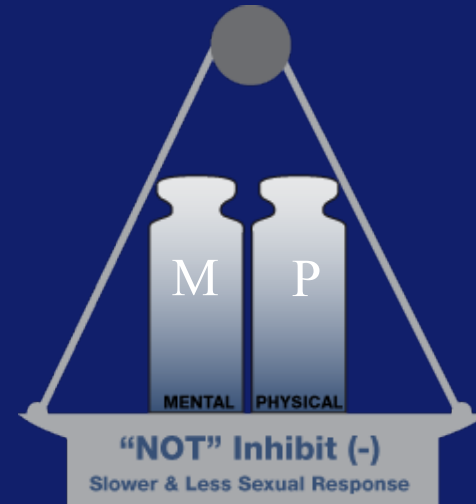
## First:

Recognize that SD is always a function of Bio-Psychosocial-Behavioral & Cultural Factors.



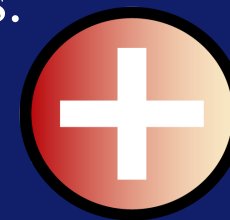
## Second

An individual's sexual function at any given moment in time, is determined by the net summary of those factors.



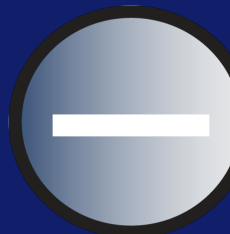
## Third:

Identify the key interfering factors as initial treatment targets.



## Fourth:

Inspire hope by explaining the STP formulation, and the initial treatment targets to the patient.





## 2nd Agenda Item: The Sex Status Is Key To Success

- How do I identify all those STP factors?

Whether a physician with ~ 7 minutes  
Or a sex therapist with ~ 45 minutes  
The answer is obtaining a **sex status**.



- The sex status is not a questionnaire or test.
- It is a flexible, focused history taking method to uncover the key psychosexual-behavioral & cultural factors.

# **STP & Sex Status: Key Concepts to Optimize Diagnosis & Treatment Of Sexual Dysfunction**

## **How do we do that?**

**By asking focused questions;**

**stepping back and then probing again,  
depending on the patient's comfort  
with the inquiry.**

## **What do you need to know?**

# Key Concepts & Questions To Optimize Diagnosis & Treatment Of Sexual Dysfunction

A good Sexual Status creates a “video picture” in your mind about the **friction, frequency, fantasy and feelings** the patient is experiencing, filtered through the lens of identifying the factors that precipitate and maintain the their Chief Complaints.

## HOW DO YOU DO THAT?

Althof, Rosen, Perelman, Rubio. SOP for Sex History, JSM, 2013

Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S74.

Perelman, In Balon & Segraves, 2005

Perelman, In Goldstein, FSD, 2005

# Sexual Status Exam:

- “Tell me what you mean by\_\_\_\_.” ( the CC)
- “What do you think is causing this problem?”

## ASK, LISTEN, CLARIFY,

- For me, the best single question you can ask is:
- “Tell me about your last sexual experience”
- That gives me a “video picture” in my mind,  
that helps me identify immediate and remote causes.

Perelman MA. *Int J Impot Res.* 2005;15(suppl 50:S67-S74.

Perelman, In Balon & Segraves, 2005

Perelman, In Goldstein, FSD, 2005

# Sex Status Exam

## What Are The Critical Evaluation Issues?

You want to answer these questions:

1. Does she have a sexual disorder, and what is the diagnosis?
2. What are the key underlying organic and/or psychosocial factors?
  - a. What are the “immediate” maintaining psychosocial causes (current cognitions, emotions, behaviors, etc)?
  - b. Any potential “deeper” psychological causes (predisposing, precipitating)?
3. Do any underlying organic or psychosocial factors require pre-treatment, or can these factors be bypassed, modified, or treated concurrently?

# Jack (59) & Jill (54)

- Initially referred by his urologist, Jack complained of a progressively severe ED. Sildenafil had initially helped him gain an erection, but “*no longer worked.*”
- The urologist noted that Jack’s hormones were normal and given Jack’s limited response to sildenafil, the urologist felt Jack would benefit from counseling.
- Jack reported: “*The Viagra is not working at all. Even if I get inside, I lose it. I love her and she still looks great! Its just not like it was.*”
- He’s avoiding sex because he’s afraid of disappointing her and himself with poor quality erections. “*Who wants to do what they don’t do well.*”
- While very distressed about his ED, Jack was eager to restore what he described as a great sexual relationship between himself and his wife of 20 years with whom he had “*a wonderful marriage.*”

- The sex status revealed a lack of any direct foreplay beyond kissing & cuddling, as Jack only concentrated on Jill (*“never needed it before”*).
- He was unable to keep any erotic thoughts in mind once he attempted coitus, even when he had Viagra assisted erection (*“it just falls out”*).
- *“My wife is unhappy and questions if I still am attracted to her\_ I love her and she still looks great! Its just not like it was.”*
- I explained about the normal need for more direct sexy stimulation (friction) and thoughts (fantasy) as one ages.
- I suggested he try masturbating while taking sildenafil and using erotica. He was to try to make it fun and not a test.
- Jack’s confidence was boosted as we spoke. He seemed hopeful and optimistic.
- Jack indicated that Jill was eager to have sex with him, and reportedly wanted to participate in the sex therapy.
- We scheduled a follow-up couples’ appointment with an option for her to choose having some session time with me alone as well.”

- Next session Jack reports: *“Good news and bad. Masturbating with the Viagra worked well!. But a few days later we tried to have sex... I got an erection having used Viagra, but it still fell out almost immediately!”*
- I asked them to describe their last sexual experience in detail. Jill interrupted Jack.
- Per my invite, Jill asked if she could speak to me alone. Jack left the room temporarily.
- She described her desire to be with Jack, mentioning how the foreplay was pleasing and satisfactory for her, but then discussed their coital failures... she grimaced... I explored.
- She cried: *“I want sex because it used to be so good. But sex hurts now, my orgasms are muted and I have no real desire left. It’s been like this since my menopause began, when I went off the pill ~ 2 years ago.”* She felt only, *“deadened sensations”* and somewhat correctly attributed their problems to mutual aging. She reported very high intimacy with her husband and love. *“But we are so confused about our sex problems. My gynecologist says its normal to stop at our age. I tried using the lubes she suggested; he felt less, it still hurt.”*
- Jack rejoined us and self-consciously admitted he’s aware it hurts her. He felt guilty they never talked explicitly about her pain, but he was convinced his *“ED was the problem alone, and she had gone along with that theory.”*
- **They did have age related change, but had not received adequate help adjusting.**



# Optimize Treatment Using the STP Model Typology

- Diagnosis: Sex Status to ID CC and Factors Potentially Causing the SDs.
  - Immediate Causes
    - Insufficient stimulation : both foreplay for him & non-sexual cognitions!
    - Rule out substance use/abuse issues... their one wine glass actually helped.
    - PAIN & Missing needed physical exam & labs to ID any underlying disease
  - Mid-level Causes
    - Assess level and source of anxiety and depression: Lack of treatment options offered by her gynecologist and mutual misinformation.
    - Partner Issues: Their previous sexual script
  - Deeper Causes:
    - His Mom's suicide and his subsequent abandonment fears.
- Initial Treatment Plan
  - New gynecology referral for Jill
  - Wean Jack from Viagra & use masturbation to increase awareness of his likes/ dislikes.

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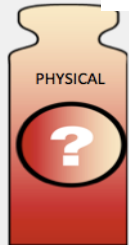
Relevant?

# Follow-up Using the STP Model

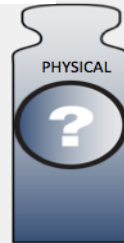
- New Gynecologist's Report:
  - "... severe vulvar vaginal atrophy... vagina admits only one finger, with adhesions between the anterior and posterior vaginal walls inferior to her cervix."
  - Rx. "... topical and intravaginal estradiol cream nightly for two weeks, and then reduce to 3x/week when she begins using a soft medium sized dilator to remodel her vagina, once well-estrogenized. Avoid vaginal sex until it can be accomplished without pain, 4-6 weeks."
- Transdisciplinary Sex Therapy Using STP Model
  - Besides ED, he had reported suffering non-coital DE (convenient for me).
    - It allowed the 5 week "no penetration" break to re-establish arousing "outer-course;" first with simultaneous mutual masturbation. Her vagina gradually improved with the Estradiol cream. She brought him to orgasm manually (his first), and as they already knew how, he reciprocated to her. Enhancement techniques were discussed during the next few sessions, as their sexual success improved, so did their mood and confidence.
    - At their 9<sup>th</sup> session they sheepishly reported having had successful "unauthorized intercourse" with mutual orgasms. Hers was still "muted".
    - While she's willing to consider androgen augmentation or flibanserin at some future date, they wanted to wait and just enjoy their renewed sexual intimacy for now.

# Agenda Item 3: Future FSD Treatments

## There Will Be New Drugs



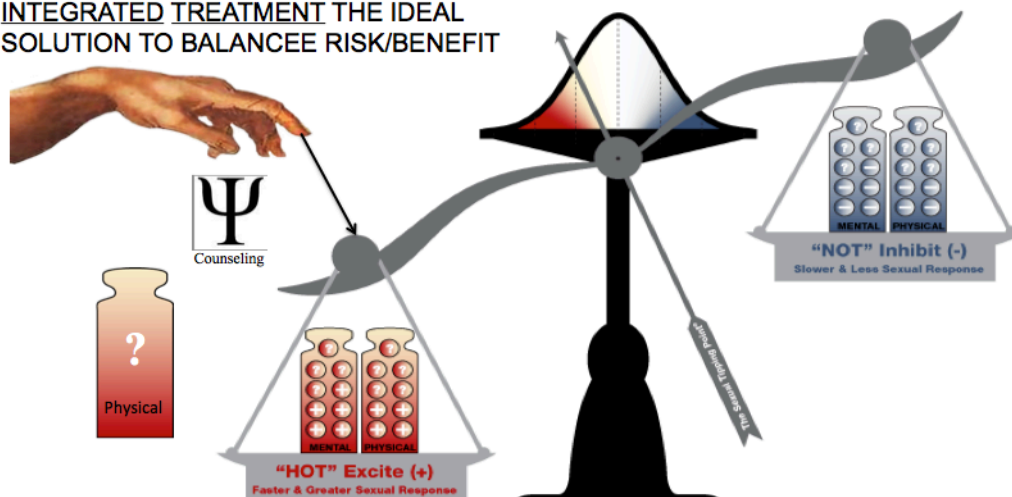
WE WILL BETTER UNDERSTAND HOW THE BRAIN MANAGES TO BOTH INHIBIT AND/OR EXCITE, AND WILL DEVELOP DRUGS AROUND THAT KNOWLEDGE MAKING PERSONALIZED SEXUAL MEDICINE A REALITY!



Transdisciplinary Research

## Sexual Balance: STP Illustrating an Integrated Treatment of HSDD Secondary to VVS & ED

INTEGRATED TREATMENT THE IDEAL SOLUTION TO BALANCE RISK/BENEFIT



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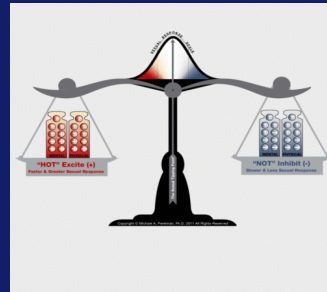
Collaboration in which exchanging information, altering discipline-specific approaches, sharing resources and integrating disciplines achieves a common scientific goal (Rosenfield 1992).

# CONCLUSIONS:

- The Sexual Tipping Point<sup>®</sup> model illustrates and provides a conceptual framework for understanding the complex and dynamic **intra and interpersonal variability** of both sexual function and dysfunction.
- The **flexibility** of the **STP** model allows for the incorporation of future advances in our understanding of biologic aspects of sexual response etiology and for the illustration of **future** novel treatments.
- Obtaining a focused **sex status is key** to diagnostic and integrated treatment success.
- The STP model can help you optimize the diagnosis & treatment of FSD within a **transdisciplinary** framework.

# The STP Model Helps Optimize The Diagnosis & Treatment Of FSD

Thank You  
For Watching And Listening!



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For questions contact [michael@mapedfund.org](mailto:michael@mapedfund.org)