

Weill Cornell Medicine, Department of Urology
Monthly Andrology Conference, May 8, 2018

Sex Coaching:
Optimizing The Diagnosis & Treatment Of Sexual Dysfunctions

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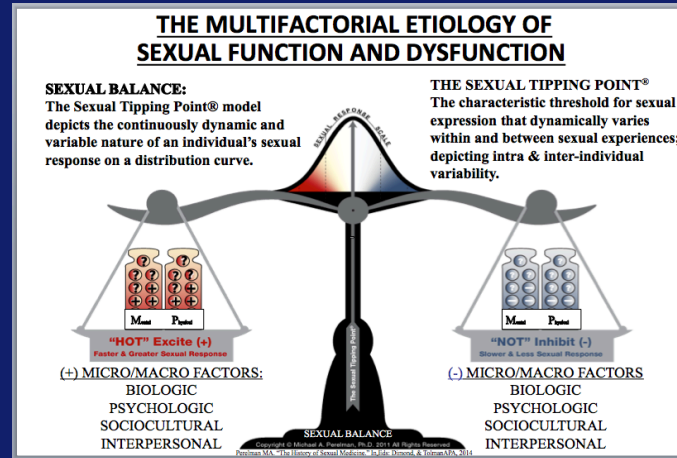
Weill Cornell Medicine

New York, NY, USA

2018 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

The STP Model Helps Optimize The Diagnosis & Treatment Of SD



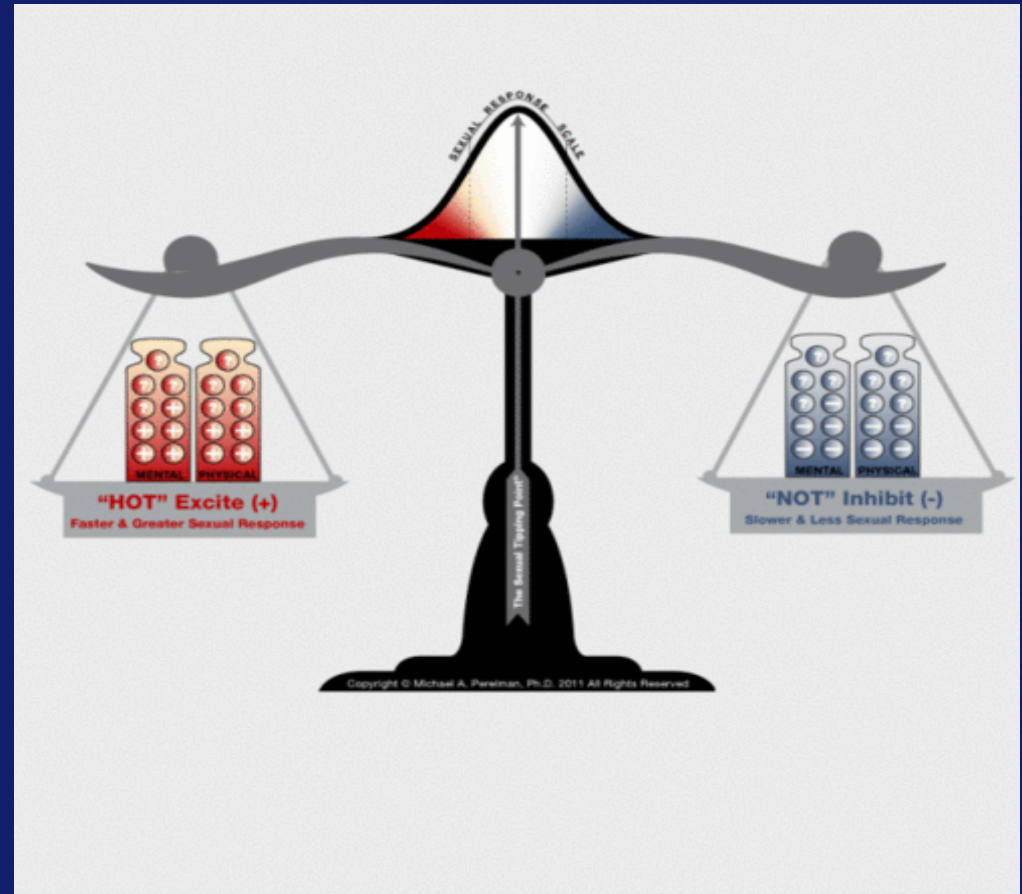
AGENDA

1. Describe the Sexual Tipping Point® model's integrated approach to illustrating the etiology, diagnosis and treatment of SD.
2. Taking a "sex status," and its use within a STP framework.
3. Discuss an SD case that integrates sex coaching.

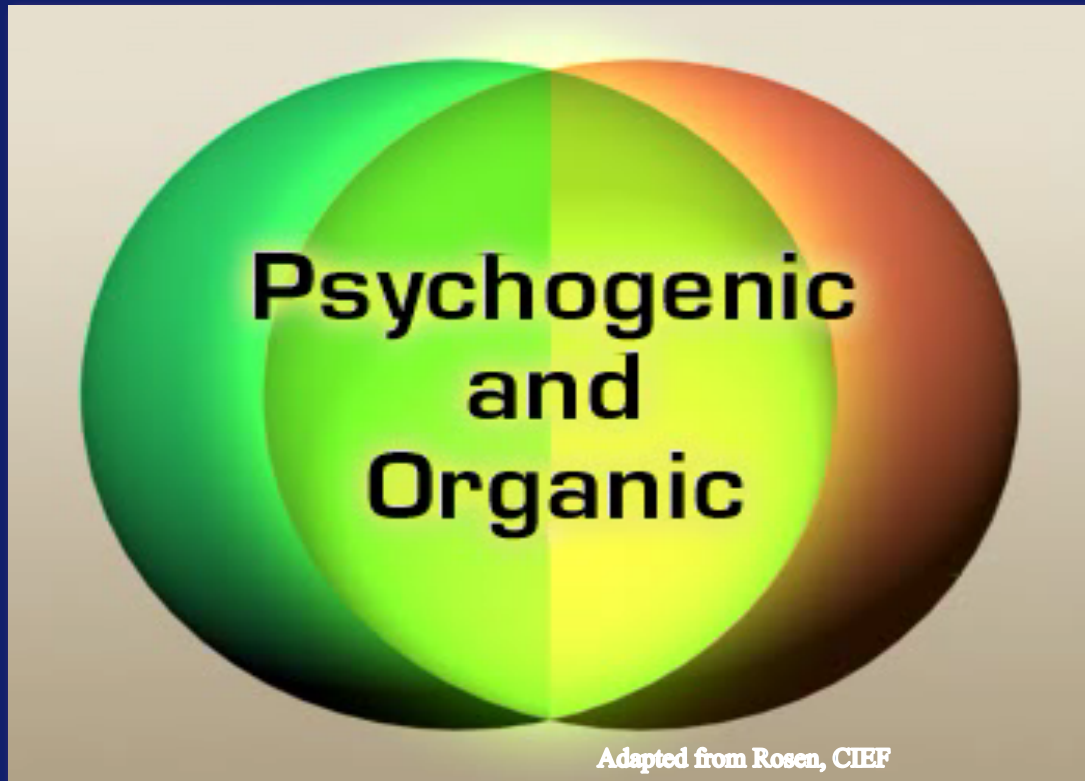
The STP Model Helps Optimize The Diagnosis & Treatment Of SD

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

Why?



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

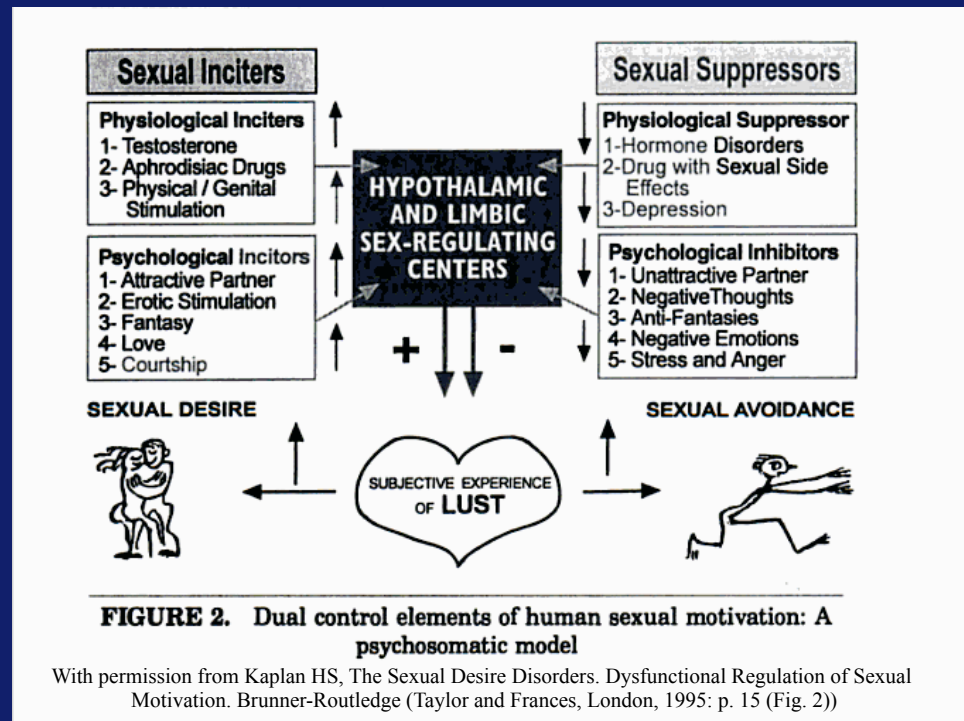
**The dynamic combination of all these factors
determines a unique Sexual Tipping Point®**



BIO-PSYCHOSOCIAL MODELS OFFER EXPLANATION FOR SUCH INTERACTIONS

Helen Kaplan was first to publish a “Dual Control” psychosomatic model of sexual motivation in 1995. An artist by training; a copy of her illustration is below. Kaplan anticipated the well known “Dual Control” models of Bancroft et al, Perelman & Pfaus.

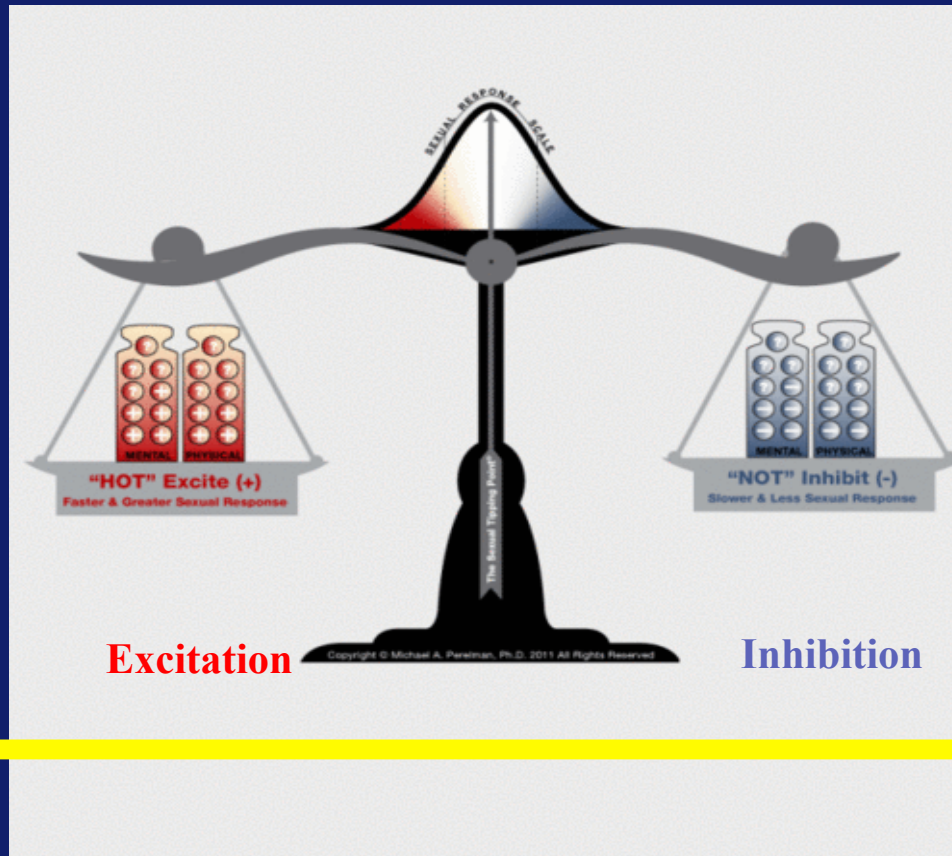
Sexual Inciters



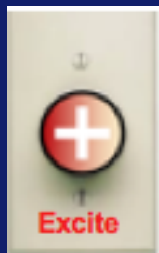
Sexual Suppressors

But The Sexual Tipping Point Variable Control Model, Better Illustrates All The Intra And Inter-individual Variability Characterizing Sexual Disorder Etiology, Diagnosis and Treatment

Whether Sex Will Be Hot or Not!



Insipient
Metabolic
Syndrome

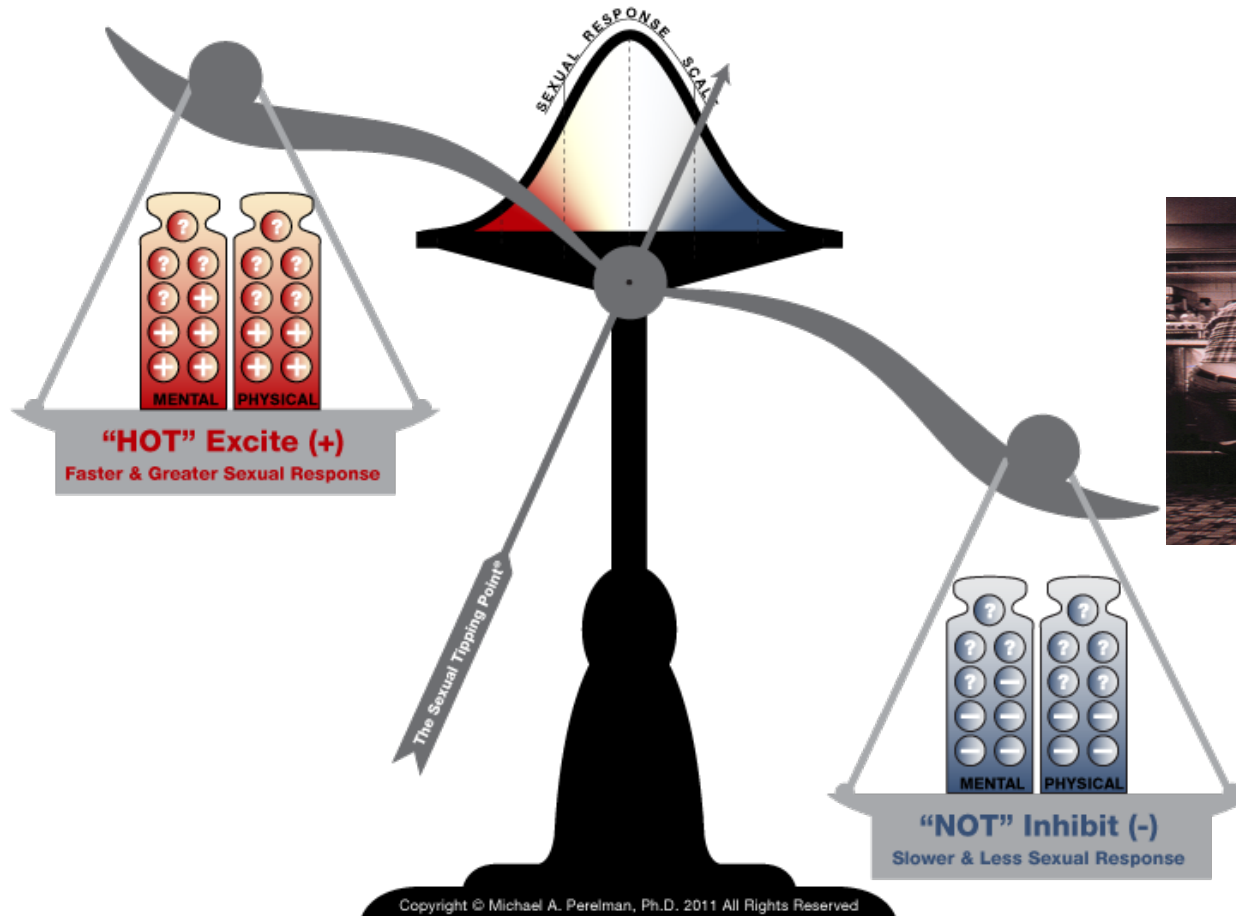


"HOT"



"NOT"

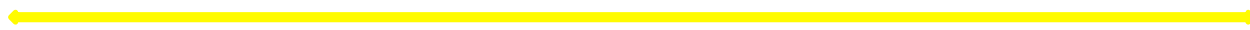
Whether Etiology Is > “Physical” = Bio-Medical Etiology



Metabolic Syndrome



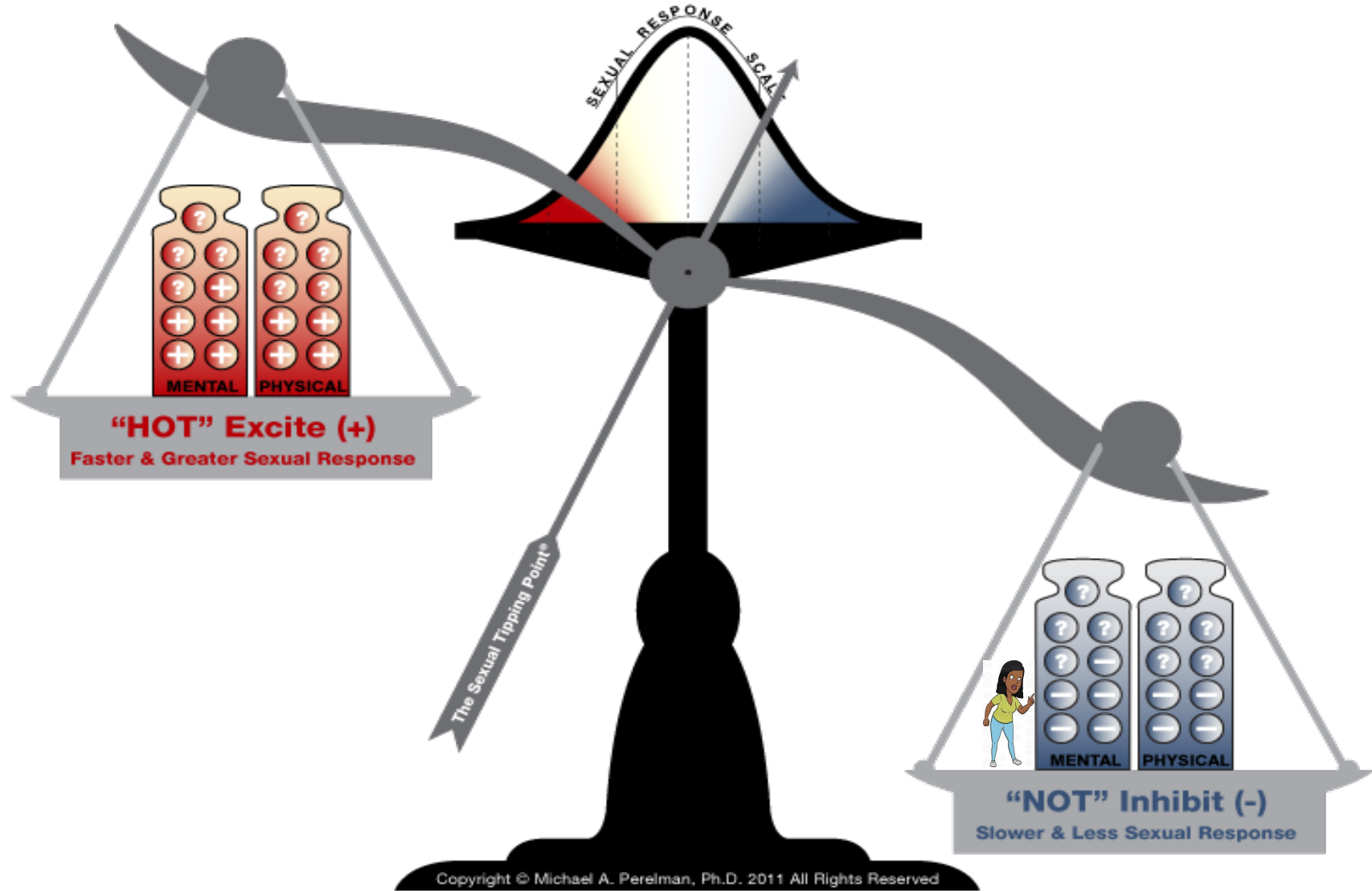
Not Hot enough



“NOT”

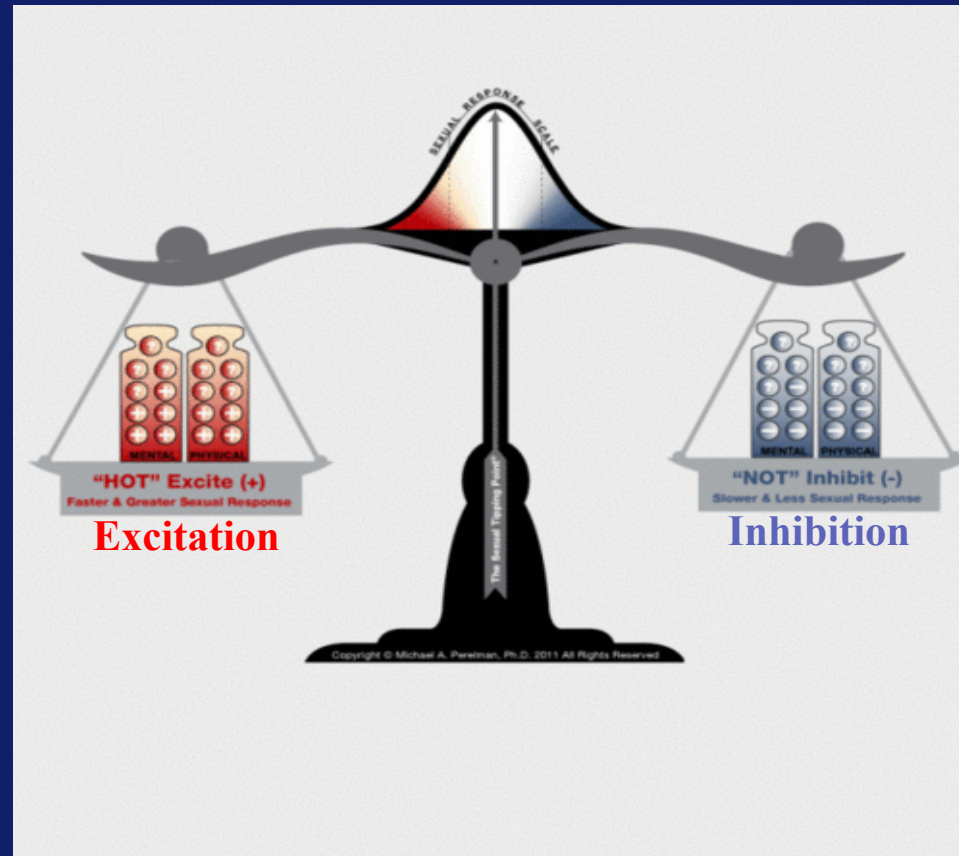
Or Mental = Psychosocial & Cultural

STP Depicting the Etiology of Patient Suffering From ED, Secondary to Being Humiliated by his Ex-wife!



The STP Also Illustrates The Intra And Inter-individual Variability Characterizing Female Response

“HOT”



“NOT”



“Cougar”

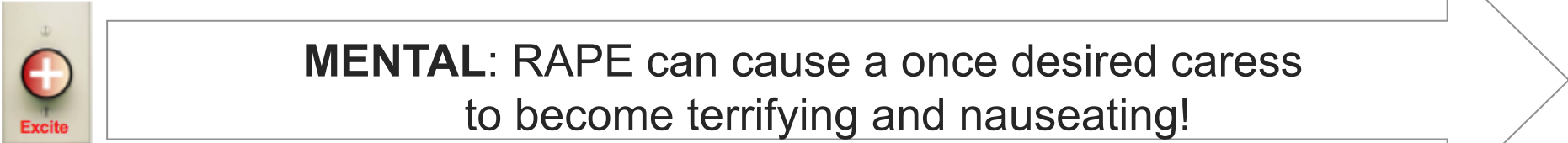


“Kitty Kat”?

STP Model: Variable Factor **Polarity** and Valence



THERE CAN ALSO BE CHANGES IN
A FACTOR'S POLARIZATION AND VALENCE



MENTAL: RAPE can cause a once desired caress
to become terrifying and nauseating!



PHYSICAL: Aging, Illness, etc, can all inhibit a once robust response



Drugs and/or side-effects can have bi-directional impact!

Sex Medicine Rx.

Cardiac, Psychiatric, Etc. Rx.



FETISH: Neutral objects can become eroticized,
Like Mrs. Robinson's stockings!

IT'S REALLY "VARIABLE CONTROL," NOT DUAL CONTROL

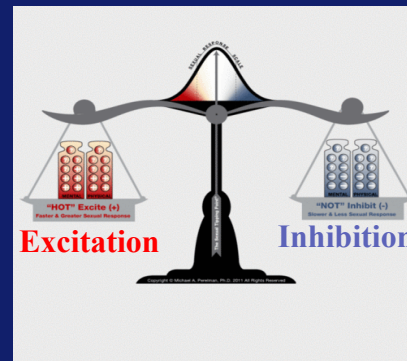
THE SMALL CIRCLES SYMBOLIZE THE FACTORS IN THE **MENTAL AND PHYSICAL CONTAINERS** AND FUNCTION LIKE DIMMER OR A MICRO VARIABLE SWITCHES.



EACH FACTORS' DIMMER HAS VARIABLE POLARITY (+,-,=) AND VALENCE



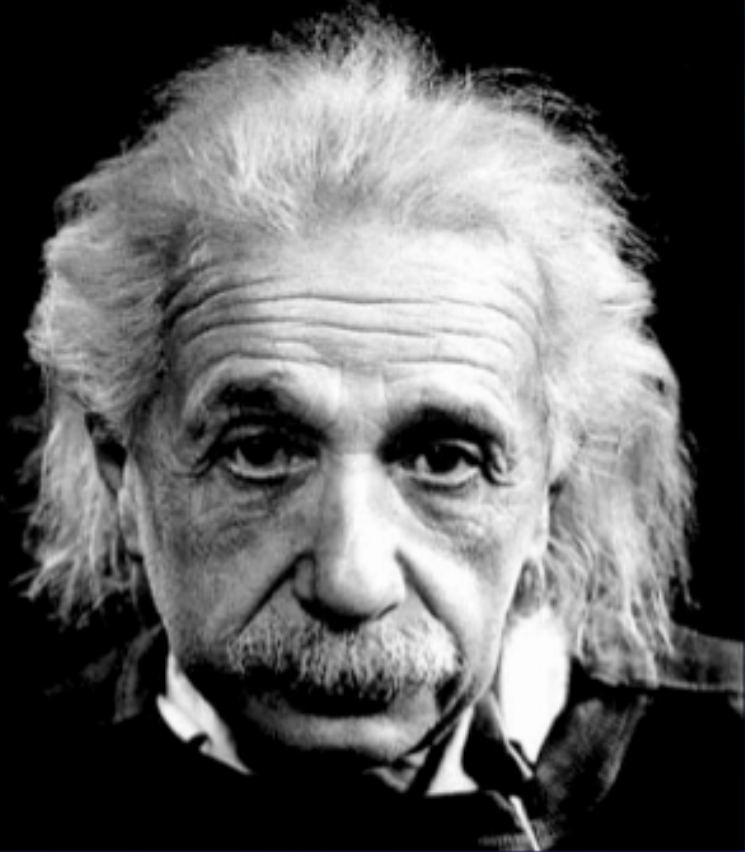
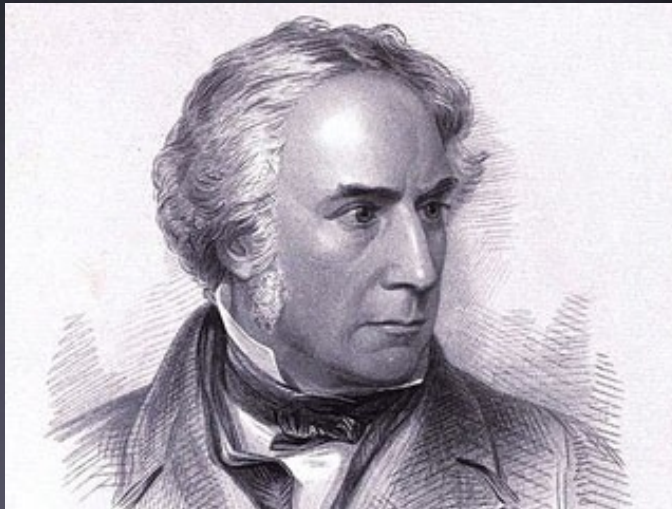
THE NET SUM OF ALL FACTORS DETERMINES THE STP DISPLAYED ON THE SCALE AT ANY GIVEN MOMENT IN TIME AND CAN BE DISTILLED INTO:



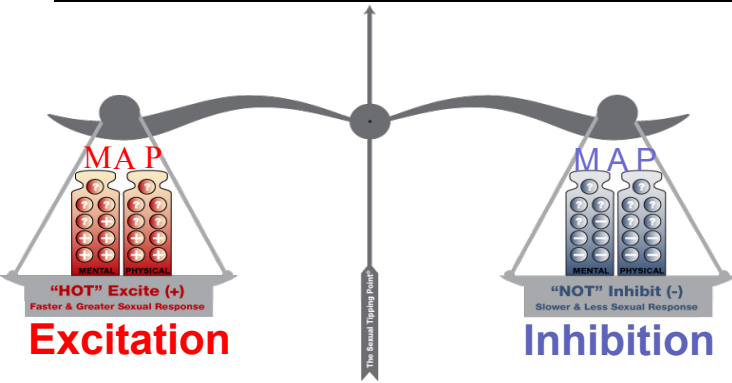
Occam And Einstein: “Make It As Simple As Possible, But Not Simpler.”

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

Albert Einstein



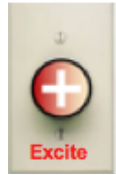
KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS



2 pairs of interconnected **containers** on
2 balance beam **pans** hold all known & unknown
Mental And Physical factors regulating sex.

Physical: “How Does The Body Turns Us On & Off?”

Bidirectional Neurotransmitters For One:



Dopamine & Noradrenaline, Help Excite & Turn us On

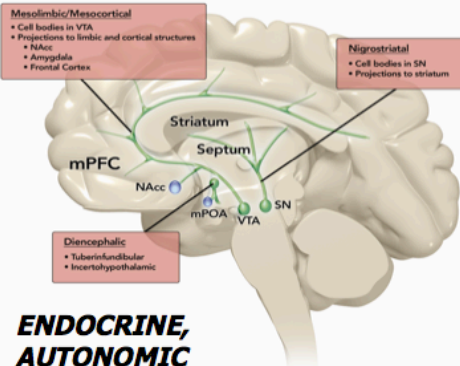


While Serotonin [5-HT], Can Inhibit & Turn Us Off

Jim Pfaus Speaks About Excitatory Brain Systems :

+

Dopamine (DA)



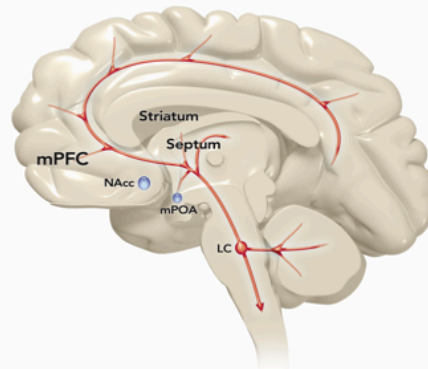
**ENDOCRINE,
AUTONOMIC
REGULATION**

**ATTENTION,
MOVEMENT**

Image Complements of Jim Pfaus, 2015

+

Noradrenaline (NA)

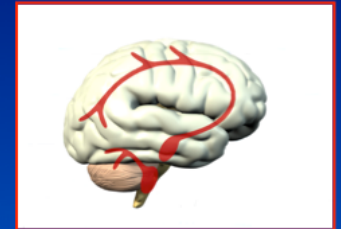


Cell bodies in locus coeruleus
Projections to hypothalamic, limbic, and
cortical regions; descending projections to
cerebellum and spinal cord.

AROUSAL

Neurological control of ejaculation

We know that Serotonin (5-HT) is a major player; 5-HT receptors and transporters are prominent in several centers in the hypothalamus, brainstem and spinal cord, and modulation of this system has been a rationale for pharmacotherapy development



What other transmitters are involved in this sexual neurophysiology?

McMahon CG et al, Disorders of orgasm and ejaculation in men. In Sexual Medicine: Sexual dysfunctions in men and women. 2nd International Consultation on Sexual Dysfunctions, Paris, 2004 pp. 417

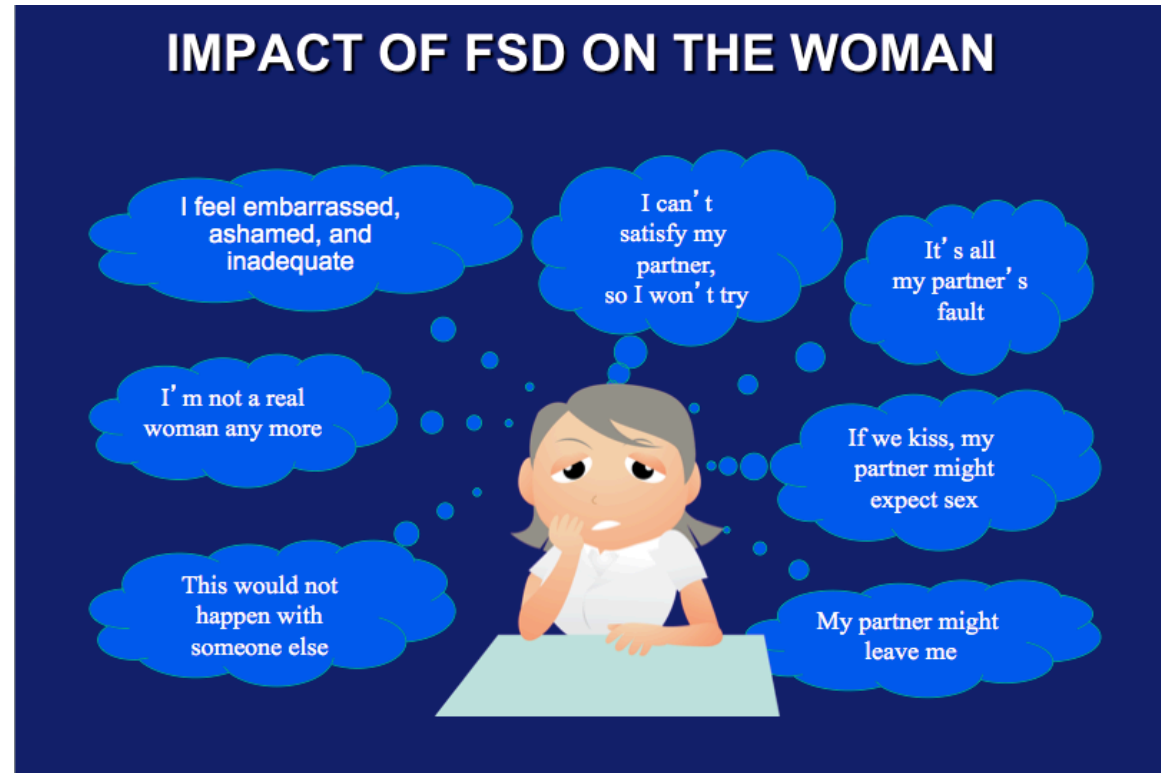
MENTAL: Fantasy Or Cognitions Can Also Be Bidirectional

Turn On 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.

Turn Off: Negative Thoughts



Complements of Eli Lilly

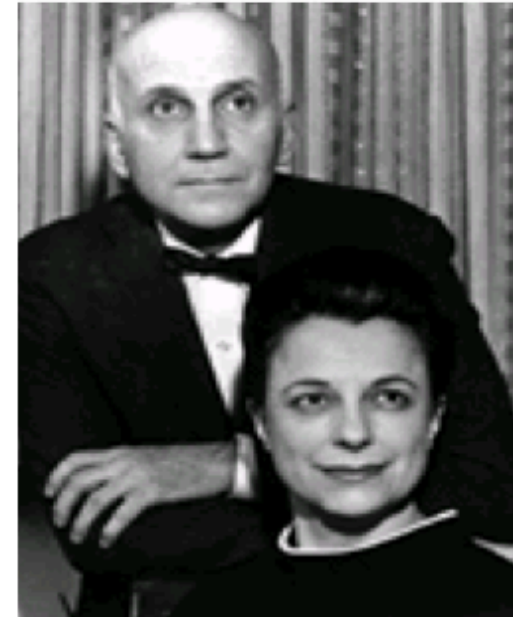
Meston, CM and DM Buss. "Why Humans Have Sex,"
Archives of Sexual Behavior (2007) 36:477.

MENTAL: Relationship Factors Are Also Bidirectional



Interpersonal dimension

- ‘there is no such entity as an uninvolved partner in a relationship contending with any form of sexual inadequacy’¹
- the non-sexual part of the relationship suffers and conflicts may arise²⁻⁶



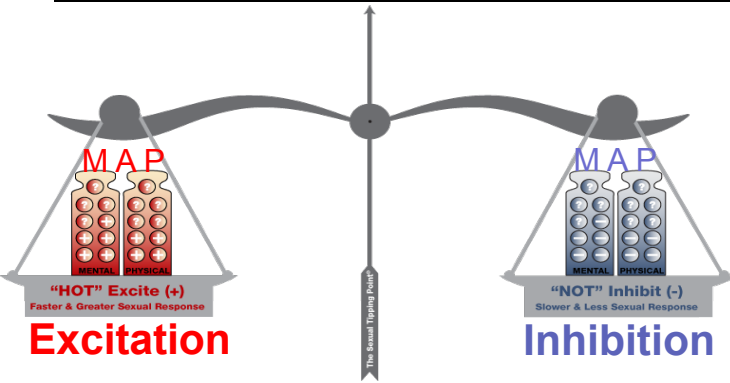
Photograph of Masters and Johnson by Buzz Taylor, courtesy of St Louis Walk of Fame

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

⁴Tomlinson J, Wright D. *BMJ* 2004;328:1037; ⁵Dean J, et al. *Eur Urol Suppl* 2006;5:773–8

¹Dunn, Althof, & Perelman, *Int J Impot Res*. 2007; 19:S99–S104

KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS



2 pairs of interconnected **containers** on
2 balance beam **pans** hold all known & unknown
Mental And Physical factors regulating sex.



Each factor's setting varies
as to its degree of **HOT** or **NOT**
Sex Positive (+) or **Sex Negative (-)**

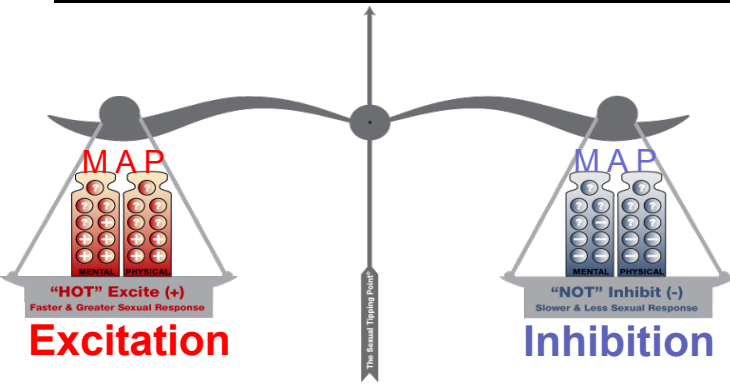


Some Factors May Be Neutral (=)



Some Factors Are Unknown(?)

KEY TO THE SEXUAL TIPPING POINT® MODEL SYMBOLS



2 pairs of interconnected **containers** on 2 balance beam **pans** hold all known & unknown **Mental And Physical factors** regulating sex.



Each factor's setting varies as to its degree of **HOT** or **NOT** Sex Positive (+) or Sex Negative (-)

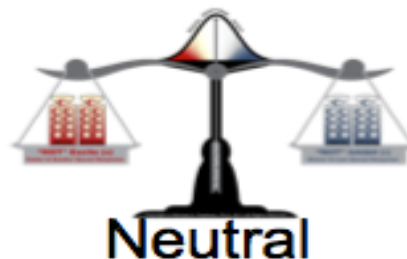


Some Factors May Be Neutral (=)



Some Factors Are Unknown(?)

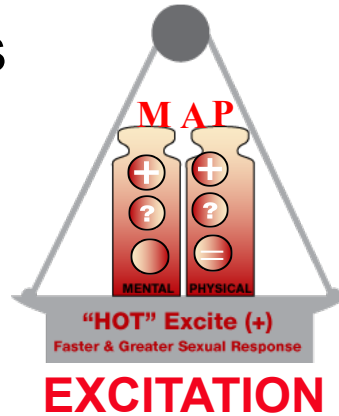
An individual's SEXUAL TIPPING POINT is displayed on a scale labeled with a Gaussian distribution curve; a dynamic representation of their sexual response at any moment in time.



So What's The First Take Away?

First:

Recognize that SD is always determined by Bio-Medical Psychosocial-Behavioral & Cultural Factors



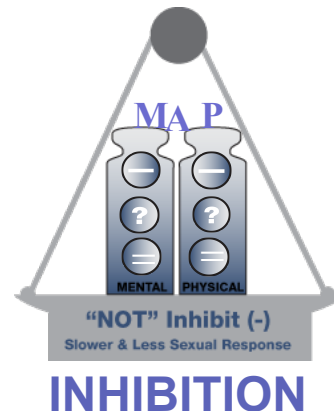
Third:

Identify the key interfering factors as initial treatment targets.***



Second:

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



Fourth:

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

STP Approach To Treating SD

- Once those treatment targets are identified, interventions can be timed, & based on whether a factor is:
 - **Predisposing**, (constitutional, prior life experience)
 - **Precipitating**, exacerbating and/or
 - **Maintaining**, a sexual dysfunction, disorder or concern.

EXPLAINING THE STP AND TREATMENT TARGETS,
NOT ONLY PROVIDES HOPE,
BUT BEGINS THE RECOVERY PROCESS
BY REFRAMING PATIENT COGNITIONS!

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

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

- How to identify those STP factors?

The answer is a sex status.

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



Kaplan HS, The Sexual Desire Disorders 1995;
Perelman MA. *Int J Impot* 2003; Res (15 Suppl 5):S67-74;
Perelman MA, FSD. In: Goldstein et al, 2005.

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

How do we do that?

Ask focused questions; step back and then probe again, depending on the patient's comfort with the inquiry.***

What questions?
Think "F"

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 moving forward, depending
on the patient's response with the inquiry.*

What questions?*
Think "F"

NO, NOT THAT "F"

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, by 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

SEX STATUS: Taking a focused sex history is critical!

- **Depending on your time** (the patient's responses and comfort level, and your own), **probe for needed details** and sexual experiences that illuminate the key factors.
- **Ask specific questions, listen, clarify:**
 - “*Tell me what you mean by DE.*” (the CC)
 - “*Tell me what you mean by PE.*” (the CC)
 - “*Tell me what you mean by ED.*” (the CC)
 - “*Tell me what you mean by no desire.*” (the CC)
 - “*What do you think is causing this problem?*”
- **This will vary with your new patients vs. established patients who are in your practice for years.**

Sexual Status Exam

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 the patient 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 factors (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 they be bypassed, modified, or treated concurrently?

REFERRAL: THE ABOVE ITEMS IN YELLOW MIGHT BENEFIT FROM ADJUNCTIVE SEX THERAPY.

Jack (59) & Jill (54)

- Initially referred by his urologist (JK) , Jack was seen alone at first.
- He complained of a progressively severe ED.
- Sildenafil had initially helped him gain an erection,

But, *“no longer worked.”*

- The urologist had noted that Jack’s hormones and physiology were normal and given Jack’s limited response to sildenafil, the urologist Rx adjunctive sex therapy.

- Jack reported:

“The Viagra is not working at all. Even if I get inside, I lose it.”

Jack (59) & Jill (54), Cont'd. 2

- Jack reported avoiding sex, afraid of disappointing himself and Jill with poor 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 Jill, his wife of 20 years with whom he had, *“a wonderful marriage.”*

Jack (59) & Jill (54)

SESSION 1

- The sex status revealed a lack of any direct foreplay for Jack beyond kissing & cuddling, as he only concentrated on Jill
He quipped: “I never needed it before.”
- He was unable to keep any erotic thoughts in mind once he attempted coitus, even when he had a Viagra assisted erection.

Jack: “it just falls out.”

*Jack: “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.”

Jack (59) & Jill (54)

SESSION 1

- I explained about the normal need for more direct sexy stimulation (**friction**) and thoughts (**fantasy**) as one ages. [STP Factor Targets]
- I suggested he try masturbating while taking the Viagra 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 & 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 Jill to have some individual session time with me as well.

Jack (59) & Jill (54)

Session 2

- 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 as he began to speak.
- **Per my initial invite, Jill asked if she could speak with me alone.**
- Jack left the room temporarily.

Jack (59) & Jill (54)

SESSION 2, Cont'd.

- Jill 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.
- She cried: *“I want sex because it used to be so good. 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, *“deadened sensations.”*
- Jill correctly attributed some of 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.”*
- **She also revealed important historical information, details for you in a moment.**

Jack (59) & Jill (54)

SESSION 2, Cont'd.

- Jack rejoined us and self-consciously admitted he was aware that sex hurts her now. He felt guilty as they never talked explicitly about her pain, but he'd been convinced, *“my ED was the problem alone, and she had gone along with that theory.”*

**THEY HAD AGE RELATED CHANGES,
BUT HAD NOT RECEIVED ANY REAL HELP,
IN ADJUSTING TO THEM!**

Jack (59) & Jill (54)

• My Case Formulation

■ Immediate Causes or Factors

- Insufficient stimulation: The foreplay for him is inadequate
And his cognitions are non-sexual!
“I’m not hard enough, I’m hurting her, etc.”
- Ruled out substance use issues: **their one glass of wine probably helped.**
- Needed a consult re: Her PAIN! Pelvic, labs, etc.

■ Mid-level Causes or Factors

- Partner Issues: Both stuck on wanting to use their previous sexual script

Jack (59) & Jill (54)

- **Case Formulation, continued and Initial Treatment Plan**

- **Initial Treatment Plan:**

1. **Recommended, 90 min. sessions in 3 parts:** 2 Individual (her first) & 1 Conjoint
2. I often work with client's existing physicians, but Jill agreed to a new gyn consult.
3. They agreed to a no intercourse rule until further notice. "Outercourse" was OK.
4. Recommended Jack masturbate to increase awareness of his likes/dislikes.
5. I told Jack he would be weaned from Viagra during treatment.

Jack (59) & Jill (54)

- **New Gynecologist's Report:**

- **Dx:** “Severe vulvar vaginal atrophy... vagina admits only one finger, with adhesions between vaginal walls.

- **Rx:** “... topical and intravaginal estradiol cream nightly for 2 weeks... then reduce cream to 3x/week.

- Once estrogenized, use a soft dilators to remodel vagina. Avoid vaginal sex until dilation is pain free... 4-6 weeks.”

- **Commentary:** The individual sessions gave deeper history taking opportunity.

- Besides ED, he reported suffering non-coital DE (that was convenient for me).

- The “no penetration” break allowed for emphasis on “outercourse,” increasing their manual and oral stimulation.

- He was to desist from masturbating **to orgasm**, and self stimulate to better understand his likes/dislikes.

- Case re-formulation, because of their individual sex hxs?
 - **Mid-level Causes or Factors**
 - She had a relatively high level of anxiety and depression:
 - Lack of treatment options offered by her gynecologist, and mutual misinformation had created despair, especially for Jill.
 - She was involved in a conservatorship issue re: her disabled brother.
 - Partner Issues: Both stuck on longing for a past sexual script where all was automatic, easy and satisfying
 - **Deeper Causes or Factors:**
 - While no violence occurred in the home, Jill's alcoholic father intimidated all and had open affairs.
 - Childhood sexual abuse by her father began at age 6!
 - The abuse included manual, oral, coital and anal ejaculation.
 - It stopped when her parents divorced immediately after she (age 13) revealed the abuse to a guidance counselor, who reported it.

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- Jill: *“BTW, Did he mention his Mom’s suicide?” Received permission...***

Jack & Jill, Case Re-Formulation Continued:

Deeper Causes or Factors:

- His Mom's suicide; his guilt and subsequent abandonment fears.
- Her childhood sexual abuse by her father!

Relevant: Yes & NO

Relevant?
Impact Tx?
Interventions
Timing?

- Yes, **HER** pain triggered abuse memories, risking contagious association to Jack.
 - **Yes, he was** oversensitive to women generally (abandonment fears).
 - But for Jill, this was normally a positive, given her abuse history.
 - It made Jill feel safe, in control, especially during sex.
 - (but his erection & arousal?)

• Updated Treatment Plan:

- I spoke with the new GYN regarding Jill's potential risk of even greater anxiety and depression caused by treatment stress.
- Prophylactically, the gynecologist prescribed 5 mg of Lexapro daily.
- **Otherwise I proceeded as planned...**
 - **Deeper factors were not currently meaningfully maintaining the SD.**

Jack & Jill, TREATMENT PROGRESS

- Her vagina gradually improved with the Estradiol cream.
- She used the dilators 3 times a week.
- Using the almond oil they liked in the past, they began massaging and sexually touching each other again and she was **orgasmic!**
- Enhancement techniques were discussed during the next few sessions; as their sex life improved, so did their mood and confidence.
- Time was spent helping Jill reintegrate positive feelings about herself by **emphasizing her historical resilience and coping skills.**
- She was helped with other family of origin stresses (brother).
- Jack was given assistance with his stress at work.
- Continued **cognitive restructuring** throughout all sessions.
- At their 9th visit they asked for the conjoint session first and sheepishly reported having successful **”unauthorized intercourse” with mutual orgasms.** Hers were still **“muted”** and **“different.”**
- They were delighted and pleased with their progress, **BUT**

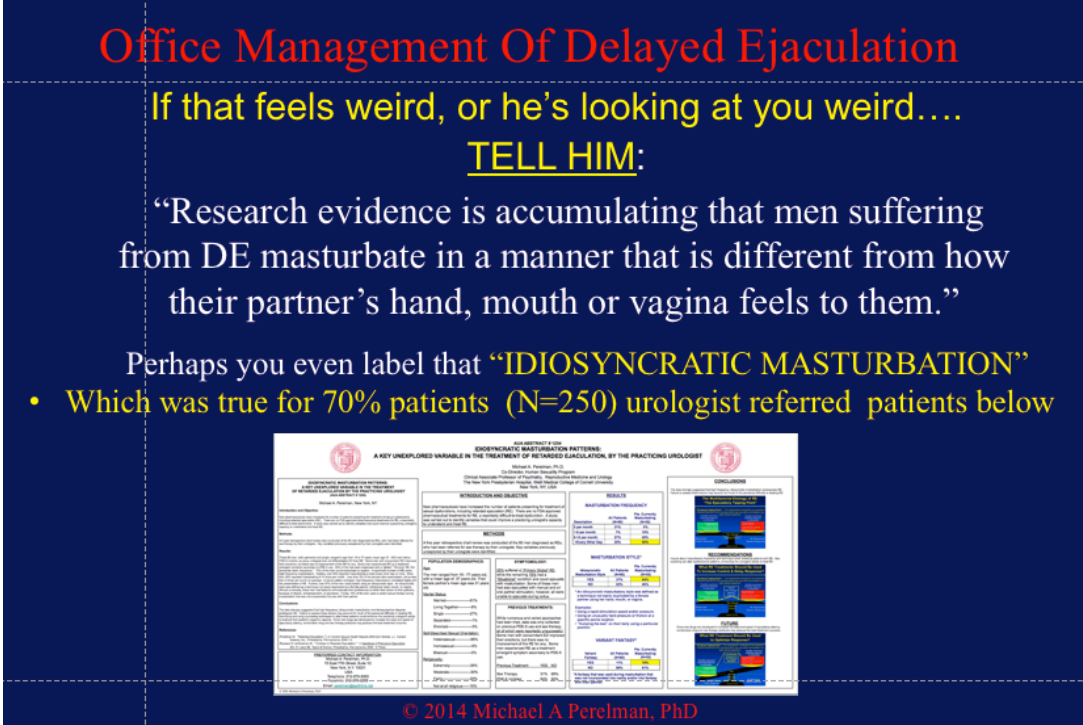
Jack & Jill, TREATMENT PROGRESS, Continued

- Because sex was so good, they decided to try again the next day.
 - No surprise, she was tender and while he was able to erect and orgasm, she had pain again and expressed concern for her future.
 - Reassurance and sex education about aging, foreplay, and lubricants was offered.
-
- Jill was told to postpone coitus again; self-explore with the 3rd/ 4th dilator.
 - Feeling better she had stopped at the 2nd before attempting coitus again.

Jack & Jill, TREATMENT PROGRESS, Continued

- He was told to stop masturbating: “If you want to come, Jill will help.”

Office Management Of Delayed Ejaculation
If that feels weird, or he’s looking at you weird...
TELL HIM:
“Research evidence is accumulating that men suffering from DE masturbate in a manner that is different from how their partner’s hand, mouth or vagina feels to them.”
Perhaps you even label that “**IDIOSYNCRATIC MASTURBATION**”
• Which was true for 70% patients (N=250) urologist referred patients below



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- The sex therapy sessions continued over the next two weeks and he finally was able to orgasm from Jill’s manual stimulation. Ecstatic response.

Jack & Jill, TREATMENT PROGRESS, Continued

- That week she fantasized about sex with Jack, while using the 4th dilator... having orgasms twice.
- The next weekend, returning home after dinner, Jill initiated and they had successful intercourse with mutual synchronous orgasms.
- This occurred again the following week.
- Treatment was terminated after three, spaced, briefer follow-up sessions.
- Jill will consider androgen or flibanserin (Addyi) in the future if needed.
- For now, they wanted to just enjoy their renewed sexual intimacy.

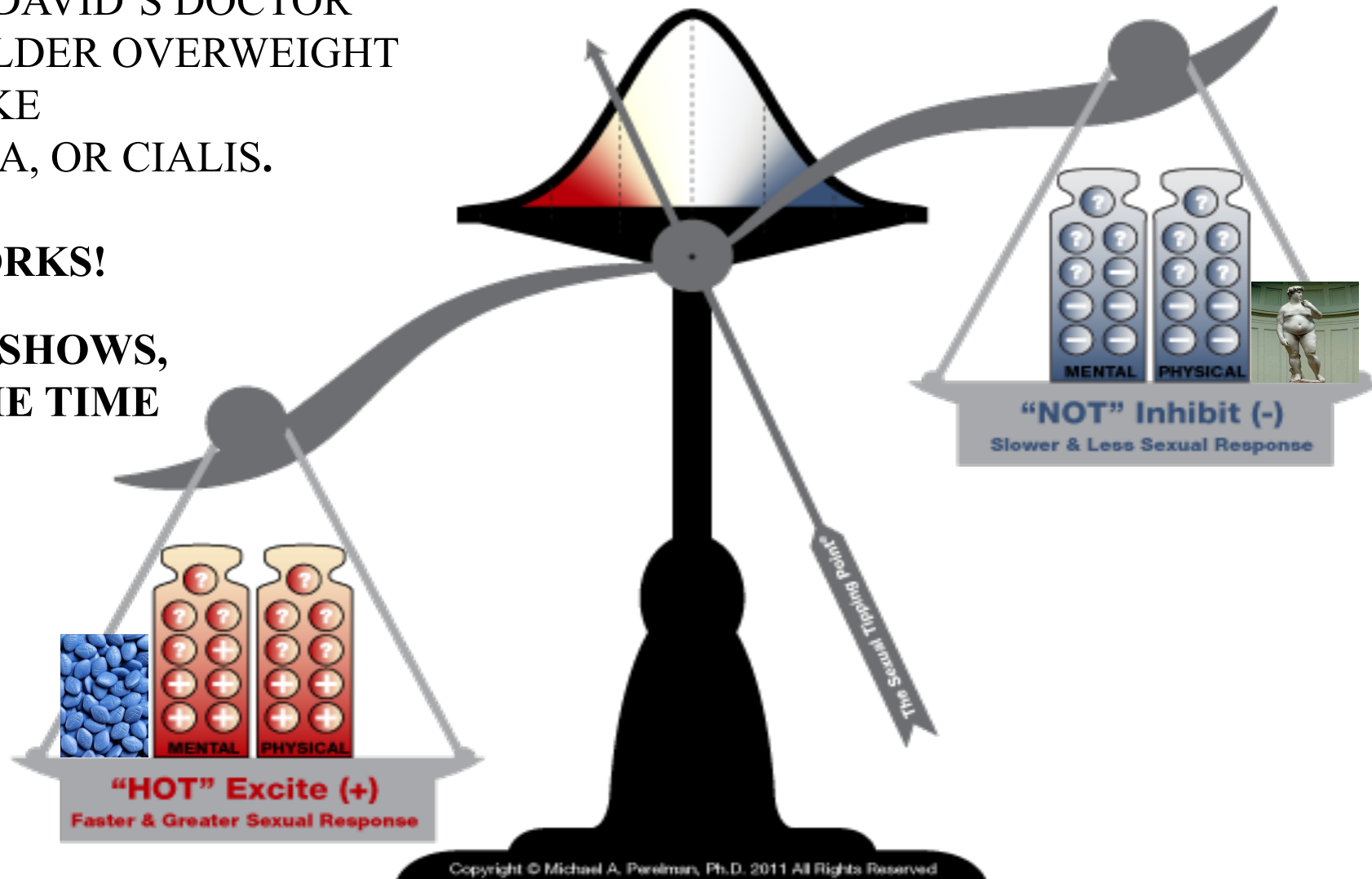
2ND TAKE AWAY, WHAT NOT TO ALWAYS DO: A TYPICAL TREATMENT FOR A METABOLIC SYNDROME PATIENT.

TYPICALLY, FAT DAVID'S DOCTOR
WILL GIVE AN OLDER OVERWEIGHT
MAN A PDE-5, LIKE
VIAGRA, LEVITRA, OR CIALIS.

OFTEN THIS WORKS!

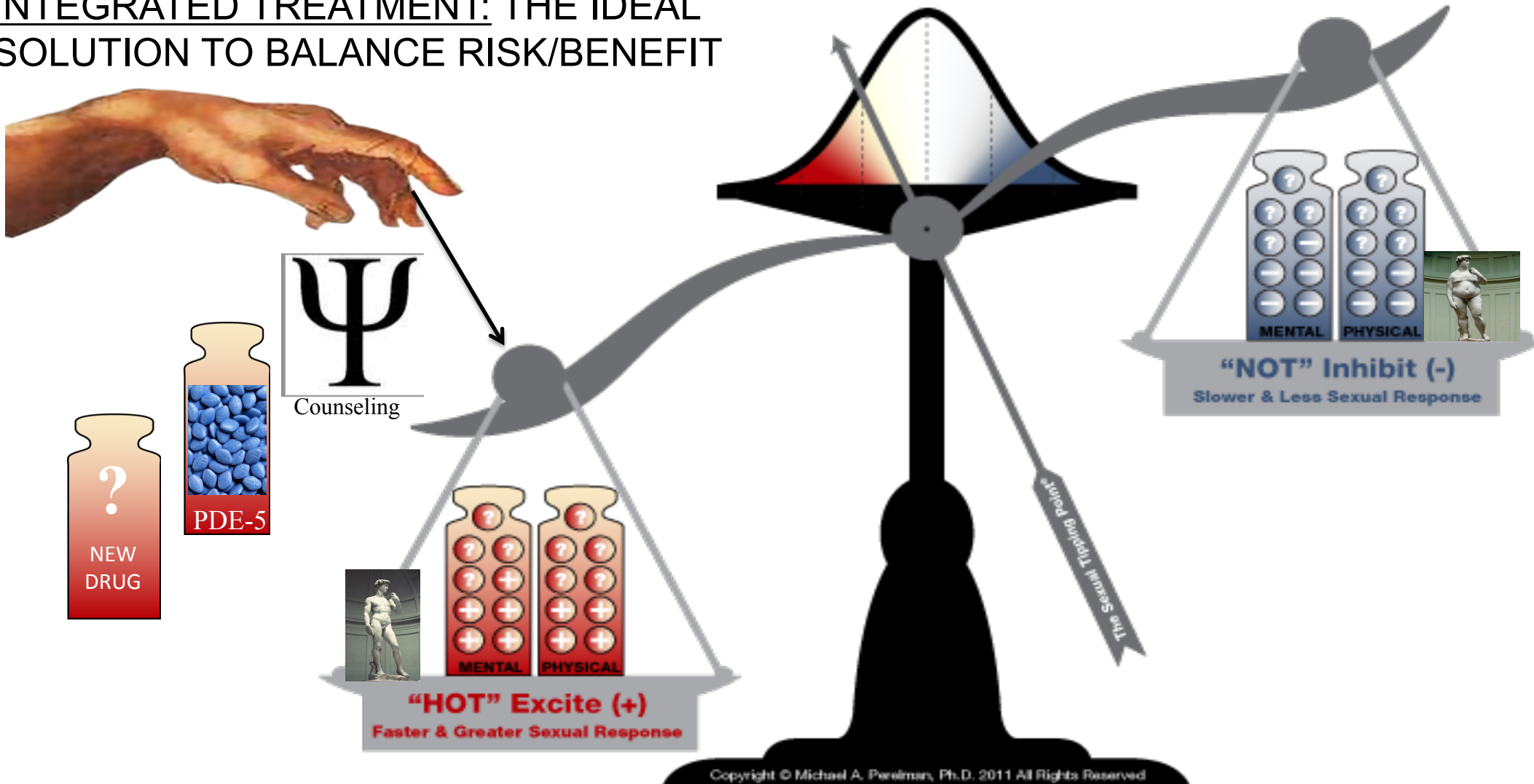
BUT RESEARCH SHOWS,
THAT 50% OF THE TIME
IT DOES NOT!

WHAT TO DO?



WHAT TO DO: AN ELEGANT SOLUTION: AN INTEGRATED TREATMENT FOR THE METABOLIC SYNDROME PATIENT.

INTEGRATED TREATMENT: THE IDEAL SOLUTION TO BALANCE RISK/BENEFIT



SEXUAL DYSFUNCTION MANAGEMENT GUIDELINES BASED ON SEVERITY OF PSYCHOSOCIAL OBSTACLES

	Mild PSOs	Moderate PSOs	Severe PSOs
Physician Sex Coach	Frequently	Sometimes	Rarely
Multidisciplinary Team	Frequently	Frequently	Frequently

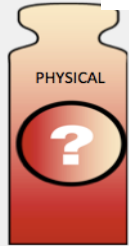
PSOs = Psychosocial obstacles

WHEN TO REFER

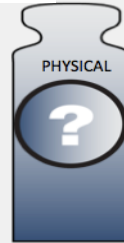
- **The More Relationship Strife, the Less Likely Medication & Education Alone Will Succeed**
- **Identifying Psychological Factors Does Not Necessarily Mean You Must Treat Them**
- **Referral**
 - **Patient request**
 - **Practice to your level of comfort**

Future SD Treatments

There Will Be New Drugs



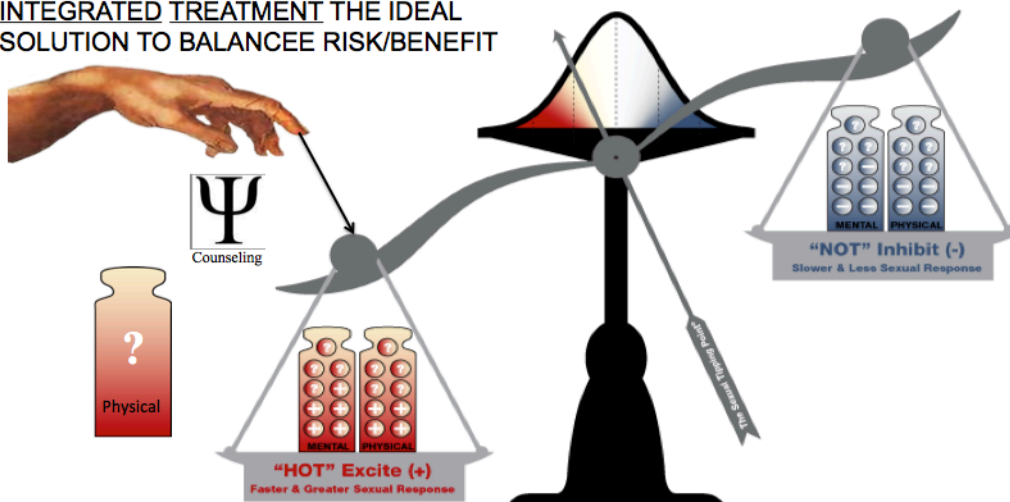
WE WILL BETTER UNDERSTAND HOW THE BRAIN MANAGES TO BOTH INHIBIT AND/OR EXCITE, AND WILL DEVELOP DRUGS AROUND THAT KNOWLEDGE MAKING PERSONALIZED SEXUAL MEDICINE A REALITY!



Transdisciplinary Research

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

INTEGRATED TREATMENT THE IDEAL SOLUTION TO BALANCE RISK/BENEFIT



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

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The STP Model Helps Optimize The Diagnosis & Treatment Of SD

Thank You
For Listening!



Other STP videos and related publications and presentations
are available free at: mapedfund.org

For questions contact michael@mapedfund.org