Counselling In Male Sexual Dysfunction: The Karnal Model

S Kalra

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Abstract

Counselling is an integral part of management of andrology, especially in patients who present with sexual dysfunction.This paper reviews the methods of counselling used for management of sexual dysfunction, as practised at the authors' hospital. The methods described below are The Karnal Model. The paper focuses on the optimal external environment, the choice of the counsellor, the hierarchy of history taking, the various sex therapies offered, based on a framework of cognitive behaviour therapy, and involvement of the partner in management of sexual dysfunction.

EXTERNAL ENVIRONMENT

Sexual function, and dysfunction, is a private matter, and the patient expects absolute confidentiality while sharing his condition with the physician. A comfortable, relaxed ambience, without external noise or disturbance, with optimal room temperature, with privacy, is essential for effective counselling.

Only the counsellor and patient should be present in the room. Interruptions by telephone or staff should be avoided.

THE COUNSELLOR

Masters and Johnson recommend counselling of the couple by a team of co therapists of both genders. However, this arrangement is not practical in many parts of the world, due to social constraints. It is also difficult in busy centres to ensure availability of male and female professionals at the same time.

The Karnal Model, therefore, utilizes one same-sex therapist for each patient. The therapist may be a qualified doctor or a trained paramedical staff member, with experience in sexual counselling. As per hospital policy, only married paramedical staff are trained in sexual counselling. This policy makes the Karnal Model practical for use in settings where social constraints prevent male therapists from talking about sexual matters to female patients/relatives. It also helps deliver sex therapy in resource-challenged environments with shortage of medical manpower.

THE ABC APPROACH

The Karnal Model relies on the cognitive behavioural therapy approach, which follows the “antecedents' lead to behaviour' leads to consequences” (ABC) framework. The consequence that the patient has presented with is the sexual dysfunction. This, however, must have been preceded by a behaviour(s) probably dysfunctional. The behaviour, in turn, would have had significant antecedents. The consequence cannot be corrected unless the preceding antecedents and behaviours are analysed, identified, and corrected.

For example, a newly married man may present with premature ejaculation, because he has been used to frequent masturbation and fast ejaculation, which is a welcome 'evolutionary' or 'adaptive' trend, when busy hostel bathrooms are used for this activity. Once this antecedent is identified, it becomes easier for the patient to analyse and correct his behaviour.

Other patients may identify childhood abuse, premarital exposure to pornography, unpleasant encounters with partners, same-sex encounters, fantasies or episodes of paid sex as antecedents for dysfunctional sexual behaviours.

Common antecedents for sexual dysfunction include stress at work, difficulties with working partners, financial strains, and physical exertion. All of these may prevent a couple from realizing optimal sexual satisfaction.

Other, simpler antecedents or behaviours may be poor personal hygiene of the partner, irritating tics and habits of the partner, or inappropriate dress, temperature or external environment.

Once the antecedent is identified and changed, the behavior

can be corrected, and the dysfunction solved.

HISTORY TAK IN G

The ABC approach will be effective only if a complete history is taken. The confidential nature of andrological complaints makes it difficult to elicit an accurate history at times. However, following basic rules of history taking makes it easier to get correct information from the patient.

The following paragraphs describe the hierarchy of questioning which keeps both doctor and patient comfortable. The basic premise of this hierarchy is to move from non-threatening questions to threatening questions, from non-intimate issues to intimate issues, gradually.

The necessary qualities of a good sexual history taking are known as the five E's :

- experience,
- etiquette,
- empathy,
- ethnic or cultural understanding, and a
- relaxed external environment.

Begin with general questions, e g," How is your health," to 'How is your sexual health?"

First ask questions related to the distant past ("Did you experience any problems in adolescence / puberty?") before enquiring about present complaints.

While eliciting the present medical history find out about non sexual symptoms (symptoms suggestive of skin infection or urinary tract infection) before trying to ask questions regarding sexual function.

During the sexual history first probe non-genital aspects ('Do you have any problems with foreplay' '), and then genital issues (Is there any difficulty inerection or orgasm?") Once genital aspects of sex have been broached, move from non penetrative sex history (Is there a difficulty in erection?) to queries regarding penetration (Is there any problem in insertion of the organ ?")

A similar non threatening to threatening hierarchy is followed while taking history of exposure to pre or extra martial contact. One can begin with queries about adolescent fantasies, move on to pre marital sexual contact, experiences and difficulties, and then probe current marital sexuality. Extra marital issues should be asked later, and same sex fantasies, non penetrative sex, and penetrative intercourse explored last of all [in this order].

The slightest verbal or non-verbal cue of discomfort on part of the patient should prompt a change in questioning. For example, the patient might appear relaxed while talking about lack of erection, but may turn red or begin to fidget in his seat when asked about extra-marital exposure. In other circumstances, a person may be communicating very well with the counsellor, but may suddenly become quiet when questioned about incest. These are markers of possible etiology of dysfunction, and at the same time, are pointers to the fact that the patient needs more time to relax with the counsellor.

SEX THERAPY

Various types of sex therapy or behavioural therapy are used in andrology. The Karnal Model utilizes an eclectic combination of

relaxation therapy

vivid imagery

Masters' and Johnson therapy

pelvic floor muscle exercises

gradual desensitization

cognitive behavioural therapy.

The following sections describe the methods in which common andrological or male sexual dysfunctions are handled. Both non pharmacological and pharmacological treatment modalities are used in combination to ensure optimal therapeutic outcome.

ERECTILE DYSFUNCTION

After taking an informed verbal consent of the procedure that will be followed, the patient is asked to take a sublingual tablet of sildenafil 50 mg or apomorphine 2 mg and relax in supine position, in a dimly lit, quiet, and isolated room with comfortable ambience, alone for 15-30 minutes.

The therapist enters the room and begins general conversation, making the patient feel relaxed. The therapist then begins instructing the patient to imagine a pleasant

fantasy,e g, being alone at the beach, or on a hilltop, or in a hotel room. Rules of vivid imagery are followed.

Once the patient has imagined this, he is taught a series of progressive muscle contraction and relaxation exercises, beginning distally to proximally. He first contracts, and then relaxes various muscle groups of the lower limbs, followed by upper limbs, and then by the head, neck, chest and abdomen. After each relaxation, the patient is encouraged to feel released and comfortable, while imagining himself in the same fantasy, alone.

After completing muscle contraction and relaxation, the patient is encouraged to repeat the exercise, with vivid imagery,imagining that a preferred sexual partner is facilitating the muscle relaxation.

The first session may conclude here,with a plan to have a repeat session later, if the therapist feels that the patient has not relaxed fully.

If, however, the patient is comfortable,the therapist moves on, He asks the patient to imagine that all the energy,released by the progressive muscle exercise, is transferred to the genital area. Once the patient begins to feel 'heat' in the genital area, he is encouraged to practice self stimulation, practising vivid imagery of a preferred partner.

Usually this procedure leads to a successful erection, either at the first or subsequent visits. Once the patient achieves this erection, he is asked to reach an orgasm on his own.

Liberal encouragement of the patient is done, and he is motivated to try out these exercises at home, in a suitable environment, alone.

After he is able to experience adequate erection, ejaculation and orgasm alone, with vivid imagery, the patient is asked to try the same exercise with a partner, without trying to achieve penetrative intercourse.

Success in these exercises leads to enhanced confidence in the patient, who by this time, is usually able to achieve good erectile function in the bedroom.

PREMATURE EJACULATON

The same framework is followed as mentioned above. When the progressive muscle relaxation and contraction is over, the patient is taught pelvic floor exercises.

A sample instruction talk is as follows: 'Imagine that you are travelling in a bus, and suddenly feel the urge to pass urine. Contract your muscles so that you stop the flow of urine. Feel your penis moving and contracting. Maintain this state of tension for 30 seconds.

Now release this tension, and pretend that you are passing urine, for 30 seconds. Feel the penis relaxing and softening.

Contract the muscles again, after 30 seconds,and maintain this alternate contraction and relaxation for 10-15 minutes.

Once this is done, perform the same exercise with anal muscles, contracting and relaxing the anal sphincter, while pretending that you are interrupting or are passing stool.'

Regular repetition of these exercises improves pelvic muscle tone and helps improve duration of erection.

During therapy, the patient is taught to utilize these exercises the moment he feels the urge for ejaculation during sex. The key is to transfer thoughts of ejaculation to micturition or defecation,for a few minutes, prevent premature ejaculation, and then restart the act.

DESIRE DISORDER

The same framework is followed as mentioned above. While performing the muscle relaxation exercises, various examples of vivid imagery are used, and the patient asked to comment on their effectiveness.

The patient is encouraged to touch himself on every part of the body, in every way possible, varying the force,direction, pressure and method of his stroke, using different parts of his fingers, palms and hands, This exercise helps him create a sexual identity for himself, identify various sensate focus spots and erogenous zones, in his body, assess his sexual preferences, and communicate these to his partner.

The next step is to receive touch from the partner, in a passive manner. The partner is asked to touch the patient, again, on every part of the body, in every way possible.

Passive touch then gets converted to active touch, with the patient keeping his hand on the partner's hand, and guiding her to his preferred zones, in the mutually acceptable manner.The patient is instructed to begin with non-sensual or non- genital areas of the body,then to move to the breast area, and to fondle the genitals last.

Verbal communication between both partners is encouraged, and they are asked to find positive non-sexual attributes in

each other as well.

PHARMA CO THERAPY

Appropriate endocrine, psychoactive and other pharmacological agents are used along with the sexual therapy, to achieve successful therapeutic outcome in the shortest time possible

THE ROLE OF THE PARTNER

The patient's partner has an active role to play in the management of andrological sexual dysfunction.

In the Karnal Model, the gynaecologist or trained female paramedical staff talks to the female partner, explaining the anatomy and physiology of male and female sexuality, the differences between male and female sexual response, and the role of the partner an optimizing male sexual behaviour.

This counselling proceeds concurrently with management of the male patient.

Each case as discussed by the male and female therapists after each session, and appropriate changes made to therapeutic strategy or planning.

We have found this approach to be more socially acceptable, less embarrassing and more effective in our setup than a combined session with therapists of both genders.

CONCLUSION

The Karnal Model is an easy, simple and acceptable method of sexual counselling. It can be used in all health care situations, including similar resource-challenged settings with social constraints.

References

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Author Information

Sanjay Kalra
Consultant Endocrinologist, Bharti Hospital