Trends in Andrology and Sexual Medicine
Series Editors: E.A. Jannini, C. Foresta, A. Lenzi, M. Maggi

David L. Rowland
Emmanuele A. Jannini *Editors*

Cultural Differences and the Practice of Sexual Medicine

A Guide for Sexual Health Practitioners

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Società Italiana di Andrologia e Medicina della Sessualità

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To special friends (they know who they are); to my family past, current, and future vintages; to really helpful colleagues who are not really friends, and to those dedicated to transcending cultural differences

David L. Rowland

To my students and my fellows, to boldly go where no sexologist has gone before

Emmanuele A. Jannini

Preface

Few human behaviors are governed more profoundly by the complex pathway of rules, thoughts, and ways of life—what we call culture—than sexuality, rendering the "science of sex" a matter particularly engaging but also immensely complicated. What is a symptom or a disease in one culture may be considered normal in another; what is largely accepted in one society is forbidden in another; what is assumed as universal (within the Western paradigm) is discovered to be local and transient. For such reasons, a transcultural perspective—although largely neglected in sexual healthcare—is an indispensable tool for understanding human sexuality.

We thus invite you to take a compelling journey into a realm of sexuality that has been under-discussed, under-researched, and often invisible to the practitioner, or even to experts in sexual medicine or sexual psychology. This journey will transport you not only around the world but deep into aspects of various cultures and subcultures. You will find it, as we have, highly educational and both inspiring and disheartening at the same time.

We view this volume as an initial attempt to provoke greater sensitivity to and discussion of cross-cultural issues within sexual healthcare, this book representing a meager though important step in a very daunting process. We are proud of the variety of topics and perspectives offered in the various chapters, of the authors who accepted our often vague challenge to bring their cultural perspectives to the fore of sexual medicine and healthcare, and of the overall tone of cultural humility and sensitivity without sacrificing principles of good practice. Various chapters will sometimes impart a sense of urgency and even desperation, though always mixed with at least a glimmer of hope—that as a community of scholars and practitioners, we have an important role to play, that we can make meaningful differences in the lives and experiences of people suffering from sexual disorders and oppression, that we can advocate on their behalf, and that we can help change policies that stigmatize and do damage.

As with any edited book, we needed to balance control and standardization of text with creativity and idiosyncrasy that emanates from various world regions and cultures. We tried to respect those variations while ensuring conformity that helps readers orderly progress through ideas and text. So expect variation in writing style as well as type of and approach toward content across chapters, yet standardization in that all authors had been tasked with drawing conclusions and suggesting practical steps/applications based on their review.

We regret that, in our first attempt, some world and cultural viewpoints are omitted or covered all too sparsely—particularly in Asian, South American, and sub-Saharan African regions, or with respect to particularly vulnerable subgroups. Be assured, it was not from lack of trying. We repeatedly found that faculty, clinicians, educators, and healthcare practitioners (especially in many less developed regions) were so overburdened in their responsibilities that adding one more commitment to their logbook was just not feasible, especially when for some it meant the added burden of working and thinking in a non-native language. We can only express our deepest appreciation to all our authors who *did* accept our bid and hope that a future volume will not only add other perspectives but also develop clinical and research models to guide ongoing efforts regarding this critically important topic.

The scientific approach to sexual health, both from a medical and a psychological perspective, is extremely young, but also rapidly maturing. We hope this volume will help students of sexual medicine and psychology, sexual healthcare givers, and researchers approach human sexuality through a fresh, transcultural kaleidoscopic lens that illuminates differences and similarities and that makes clinical practice increasingly sensitive to and aligned with patients' needs.

While each chapter was carefully reviewed and revised, the ideas, content, views, accuracy, originality, and attribution of sources for each chapter are the sole responsibility of its authors. They do not necessarily reflect those of the editors and/or the publisher, and they are neither endorsed nor given validation by the editors and/or publisher.

Valparaiso, IN, USA — David L. Rowland
Rome, Italy — Emmanuele A. Jannini

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Part I

Introduction: Editor's Notes

These initial chapters provide an overview of relevant issues and challenges faced by healthcare professionals as they adopt a cross cultural perspective—both are worth a quick read so as to acquire a broad understanding of the topic. The first chapter provides an introduction to the topic, first explaining why—now more than ever before—cultural competence is important in healthcare practice, and then illustrating how cultural variations impact the health and healthcare of individuals. Issues encountered in the clinic setting such as alternative worldviews of heath and illness, communication and language barriers, and practitioner–patient relationships are briefly discussed, with specific examples from the literature affording deeper understanding. The importance of cultural competence in dealing with sensitive issues surrounding sexuality—where culture often has a strong vested interest—is introduced, and a final section on strategies for developing cultural sensitivity rounds out the chapter.

The second chapter introduces the reader to the field of medical anthropology—the discipline that seeks to understand cultural-medical intersections and to generate new knowledge and insights within the field. As authors Wentzell and Labuski note: "Expectations of sexuality reflect the gender norms of a specific time and place…" and these differ greatly across cultures. The authors then proceed to discuss "how healthcare providers can employ anthropological insights in order to responsively treat sexual problems without causing harm." Medical anthropologists provide an intuitive understanding into the ways that the medicine of a specific place and time erroneously defines "normal" versus "pathological" by attending to medical practices as themselves parts of culture. Using two research projects to illustrate their points, they cogently demonstrate how sexual "problems" are culturally couched, and end with specific guidelines to help practitioners reflect on ways that their own ideas and actions have been shaped by particular cultural or structural influences and settings.

Culture and Practice: Identifying the Issues

1

David L. Rowland

1.1 Diversity and Healthcare: The Idea Is Not New

The conversation regarding cultural diversity and healthcare has been happening in earnest for over half a century. As far back as the 1970s, medical anthropologist Arthur Kleinman described the phenomenon of "illness without disease," the idea that negative emotional states such as unhappiness and depression may be somaticized in many cultures—not in the manner of our current conceptualization of psychosomatic illness but rather as a vaguely defined physical discomfort that has no clear underlying physical symptoms. Kleinman further noted that people in different parts of the world often have their own conceptual model of disease and along with it, how disease should be treated [1–3]. Undoubtedly, medical missionaries dating back to the nineteenth century (think David Livingstone, the British physician, explorer, and medical missionary in Africa in the 1800s!) had been well aware of such cultural differences. However, only more recently has the need for understanding diversity and cultural differences become paramount for the average practicing clinician, and only in the past 30–40 years has the issue become a topic of concern needing to be addressed at both the individual and institutional levels within the healthcare enterprise. Quite interestingly, anticipating just such a forthcoming need, back in 1978 Kleinman himself [1] suggested a set of eight standard questions that every physician needed to ask the patient (see Box 1.1).

Diversity has two elements to it. Many nations/states have historical and existing racial and ethnic populations that subscribe to their own unique set of cultural values—thus, what we might consider *domestic diversity*. And many nations/states experience an influx of non-natives who may be in transit or hoping to resettle within the host country—thus what we might consider *international diversity*. Some

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Box 1.1 Kleinman's questions [2]
- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

countries are dealing mainly with one or the other types of diversity; others are having to deal with both. And in some instances, because of the lack of health care workers in isolated parts of the world, trained practitioners may volunteer (or be assigned) to treat patients abroad who hold very disparate views about health and illness. Both types of diversity—domestic and international—present a challenge.

1.2 Diversity Is Increasing

In the USA, the impact of domestic diversity has been poignantly felt over the past several decades (even though it has actually existed for many preceding decades), particularly in some areas of the country. Hispanic and Latino ethnicities make up 17% of the US population, African Americans 13%, and other non-white races about 12%, with such groups growing substantially over the past three decades [3, 4]. Compare the 5-year growth rate from 2005 to 2010 of Caucasian whites at 5% with the much faster growing rates of 40% for Asians and Hispanic/Latinos [4]. In fact, 2050 will presumably represent the point at which the Caucasian white population becomes a minority in the USA. For some US states, that future is now, in Texas, Hawaii, California, and New Mexico.

Cultural diversity is much the status quo around the world. In Europe, for example, ethnic groups have for centuries been spread widely across various regions and nations, and with the recent influx of migrants and refugees, the impact of cultural diversity has taken on new dimensions, urgency, and repercussions. To cite examples, in Sweden in 2017 [5], about 17% of the population was foreign born, and of these about 65% were born outside the EU. In France in 2008, nearly 12 million foreign born immigrants and their immediate descendants were residents in the country, or about 19% of the total population of the time—and that population has undoubtedly grown since that census. In the Netherlands in 2017, about 22% of the population was ethnic/foreign born non-Dutch or non-Frisian. Diversity is, of course, defined by more than racial, ethnic, and non-native background, with religion, tradition, and subculture values often assuming the stronger role in

contributing to diversity of thought, feelings, and attitudes. Indeed, clinical interactions are often complicated by a range of differences: linguistic, sociocultural, religious, and ethnic factors.

But even within the European Union, different values and traditions can impact medical practice [6]. For example, some parts of Europe have held a tradition that assumes the patient has a duty to maximize his/her own health and follow physician's instructions, with the physician guided more by professional norms than by patients' rights. Thus, when relatives disagree with a physician's decision (say, regarding end-of-life decisions or treatment for a handicapped child), the physician may feel obliged to proceed to ensure compliance even when contrary to patient or family wishes. Other parts of Europe subscribe to a more patient-centered social welfare model than a professional standards model. Such models give the patient the right to override medical opinion (even when mental competency may not be guaranteed), as the approach focuses on the patient's positive rights and entitlements to healthcare, with the appointment of patient advocates being a norm when disputes arise.

Consider further the diversity existing within many non-Western countries. Some of the most culturally diverse nations are found in sub-Saharan Africa, and East Central and Southeast Asia, where cultural differences are the product of colonial histories combined with the formation of nation states based on geographical landmarks rather than homogenous peoples. The result is often a patchwork of regional and ethnic variations. Such is the situation in Pakistan, a country having eight major ethnic groups, two minor ethnicities, and some 74 living languages. Furthermore, because education often improves as people migrate to urban areas, an important demographic in healthcare attitudes and beliefs in Pakistan is that of the person's origin *and* current place of residence—rural or urban.

Beyond the anticipated, predictable societal diversification—typically characterized by changing demographics resulting from expanding subpopulations within nationally defined societies—the less predictable *international* diversification is becoming more common. Specifically, migrant health is becoming an ever-increasing issue in many parts of the world, as populations—increasingly mobile—are displaced by war, persecution, famine, economic privation, and desire for an improved lot. Such changes and their challenges—either from changing populations within or migrating populations from outside—have not gone unrecognized. In many situations, both patient and practitioner are acutely aware of and able to articulate the shared problems of diversity in healthcare.

Superimpose upon the changing demographics of national populations the fact that the physician workforce itself is also changing, and another layer of complexity is added to the situation [7]. In the USA, in 2010, medical school graduates were about 75% Caucasian, 13% Asian, 6% Black, and 6% Hispanic [8], percentages that hardly represent the current or trending demographics of that country. Patient preferences for race/ethnic concordance with the practitioner are well known [9], and given the disparity in percentage and distribution of ethnicities (patient and practitioner), the implications are significant, as outlined in the next section.

1.2.1 Subcultures Within Dominant Cultures

Cultural differences extend beyond those of geopolitical, ethnic, and national identities. Within many national cultures, subpopulations having special characteristics sometimes establish their own cultural identity. For example, in the USA and Pakistan, transgender communities have developed their own subcultures, as have members of many sexual minority groups. There are cultures of aging, cultures of disability, cultures of the homeless, cultures surrounding drug use, regional cultures, political cultures, and so on, many of which have established their own views, values, and attitudes regarding sexuality and gender. While some of these cultures have long existed, others have become more visible as societies become more open and tolerant about diverse lifestyles and beliefs. Although it will never be possible for practitioners to understand people of every subculture, having awareness of such diversity within the population enables healthcare providers to be more intentional in their efforts to be more inclusive in both their verbal and non-verbal communication.

1.3 How Do Cultural Differences Impact Health Care?

The reality is that it is becoming increasingly unlikely that health care professionals will *not* encounter patients (or families of patients) who hold values and ideas about sickness and health different from their own, or from the ones into which they have been indoctrinated through their health care education. Culture, once viewed as an explanation for ways of life and forms of understanding of distant societies, now refers to the "dominant values, symbols, social practices, and interpretive categories of any community," communities that often exist in our very midst [10]. Aspects of culture such as beliefs about the cause of diseases, pain relief, truth telling, religious beliefs and practices, the organization of social units, decision-making, and moral codes can impact interactions between patients and practitioners [10, 11]. The "clinical" realities for the patient and health care provider may, literally, be worlds apart [12].

Thus, "culture" can have a major impact on the healthcare of individuals [12]. However, often the rules of a culture are not overt or even discussed, and therefore such differences may be well hidden from view for both patient and practitioner, in some instances appearing insignificant or irrelevant. In fact, cultural norms/rules often do not become apparent until they are broken—often when it is too late. For example, most clinical environments assume that the patient will heed the physician's advice. But such an assumption may be far from the reality. Medical training—whether intentional or not—typically positions the doctor as the expert/teacher, so within a doctor-centered sphere, the naïve/unknowing patient would obviously comply with medical instructions. But a patient may be reluctant to disclose all the relevant details of the illness, may not agree with or understand the physician's diagnosis, may believe the treatment would not be sanctioned by his family or is inconsistent with religious beliefs, and/or may misinterpret the

treatment as being unrelated to the condition, all factors that would result in low or no compliance. Thus, while the practitioner—consistent with his training—sees and treats specific diseases as being similar across people [13], patients experience illness differently, often with their understanding of the disease at odds with that of the practitioner's.

1.4 Kinds of Issues Encountered

Cultural differences typically revolve around half a dozen predictable issues [11–13]: (1) the construct or meaning of disease, (2) the role of authority and who possesses it, (3) the manner and extent of communication, (4) the appropriateness of physical distance and contact, (5) the role of the family in decision-making, and (6) issues surrounding gender and sexuality. Beyond these "in-clinic" concerns, cultural differences may also impact who has access to healthcare, due to the status of certain patients within the social system (e.g., citizen or refugee), their tradition of health seeking behavior within the subculture, and the level of comfort the individual/family has with the specific health care system of the dominant culture or host country.

Although not all the concerns listed above are addressed in this chapter, discussion of several key issues offers insight into the kinds of problems encountered by patients and practitioners alike when values and traditions regarding health, illness, and remedy are disparate. These include the meaning of disease, communication issues, and patient–practitioner relationships, this last category serving as a proxy for any number of factors including physical distance and contact, family roles, and gender/sexuality.

1.4.1 Views of Health and Illness

Every culture has dealt with issues surrounding health and disease since the beginning of time, and each has developed its own explanations for those conditions [11]. Over the centuries, these ideas have become deeply engrained. The introduction of Western medicine, which until only the past century has made credible progress, represents but a small and recent chapter in the understanding of disease within cultures that may have longstanding views and traditions regarding illness and its treatment. For example, traditional Chinese medicine, which has a history of somewhere between 2300 and 5000 years, is based on the need to maintain a balance between two complementary forces, yin (passive) and yang (active), that influence the human body (as well as the universe as a whole) [14]. Health ensues when the two forces exist in harmony, and illness when that harmony is disrupted. Even though most medical training in China currently follows a Westernized approach to illness, traditional Chinese medicine remains a vibrant part of the health care system, is practiced professionally, and carries substantial street credibility, not only in China but in other Asiatic regions as well [15].

As a result of such traditions, it is often advantageous to conceptualize the patient through two lenses: that of his/her personal experience of disease, and that provided by the framework of his/her culture. Every patient—independent of cultural similarity or dissimilarity—will have probably formulated a cause for his/her health problem and tried some type of remedy prior to approaching a practitioner. The patient's purported cause and treatment are typically embedded in his/her personal experiences with health and sickness—the patient learns specific ways of being ill, and these will often differ across individuals even within a single culture. But these interpretations are further informed by the person's cultural values and beliefs. For example, if the prevailing cultural understanding of health and illness subscribes to systems of balance (e.g., the yin and yang in Oriental perspectives, the "hot" and "cold" in various Latin perspectives), then cause will focus on events or situations that have disrupted balance, and remedies will depend on steps that restore balance. For many individuals utilizing health care systems based on modern medicine, the traditional approach often serves as a "backup" strategy, especially when there is some skepticism regarding the Western medical approach.

Many patients, particularly those with roots outside North America and Europe, do not share the Western biomedical view of disease; or they accept only those elements that do not clash with their more deeply embedded traditional views. Views of health and illness often have strong religious overtones (being blessed, being cursed), and when the medical vs religious interpretations of health and illness are at odds, the religious view may well prevail. Patients may, for example, identify the origin of disease in both physical and spiritual terms (depending partly on the nature of the disease), which then may lead them to seek solutions that include spiritual mediators. In some cultures, diseases are seen to require both a physical and spiritual remedy. In a now classic account by Fadiman [16], a Hmong refugee family living in the USA in the 1980s ascribed the origin of their infant daughter's disease (epilepsy) in part to spiritual causes, leading the family to consult spiritual sources to address the spiritual causes of the disease while also consulting a physician to treat the physical issues. Due to cultural misunderstandings and mistrust, the parents failed to properly medicate their daughter, Lia, as prescribed: in part thinking it might interfere with the process of spiritual healing and in part because the concept of adverse side effects of medication was unfamiliar to them and so they were distressed by their daughter's negative reactions to medications that were supposedly healing her. At the same time, the treating physicians interpreted the family's lack of compliance as abusive and, within the purview of the best interests of the child, had the child removed from the home. The saga ends in tragedy for Lia, and the book, written in 1997 when long-term fallout from the Vietnam War was yet fomenting, was a major wake-up call in the USA about how cultural misunderstanding could wreak disastrous effects on the patient–physician relationship, destroy patient's trust in a health care system, and jeopardize the health of individuals.

Perhaps equally alarming to the practitioner of Western medicine, cultural (or subcultural) values may sometimes lead to behaviors that negatively affect the health of the larger community, such as parents refusing to vaccinate children on the

belief that the vaccines will sicken them. Some cultures have very specific anxieties, for example, related to fluid loss (e.g., blood, semen) or to the cold (that may prevent people, e.g., new mothers, from venturing outside on cold days to see the doctor). And sometimes cultural interpretations may lead to treatments that are actually harmful: The hot–cold dichotomy of Latino and Asian cultures may result in the use of noxious lead salts or mercury [11]. For such reasons, practitioners need to understand that parallel, often competing systems exist, and that although in some instances, they may be harmless, in others they may have significant and serious repercussions for the health of the individual and community. In still others, the content of the treatment may in all likelihood be harmless, but the method of delivering the treatment may inflict damage, as is the case of burns and scars resulting from acupuncture or the application of burning herbs to the skin. Clearly, as demonstrated in Fadiman's [16] account, dismissal, stern warnings, or other countermeasures are often ineffective in managing the situation. As Juckett [11] indicates, and as is further discussed in Sect. 1.4.2 of this chapter, a critically important step is beginning with a conversation that explores the patient's (and/or his/her family's) understanding of the cause of the disease and the remedies that have been undertaken thus far. Such information can aid the practitioner in obtaining a sense of the patient's social construct of health, illness, and treatment.

1.4.1.1 Stigmatization and Mental Illness

In most cultures—including yet many Western nations—illnesses that are viewed as mental or psychological (including those involving sexual issues) may present a special problem in that they are considered shameful and bring dishonor to the family. Furthermore, because symptoms are typically behavioral rather than physical, the origin of the illness may be attributed to unnatural or supernatural causes rather than to an actual disease. For example, within some groups, sadness and depression may be viewed as challenges from God, with prayer and penance being the appropriate response. Or those with dissociative or schizophrenic symptoms may be deemed possessed or even gifted (e.g., when they speak nonsensically), and so on. Indeed, according to the DSM-5 [17], personality states may be seen as an "experience of possession" as the ailing individual experiences "discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning…," signs and symptoms that may be observed by others or reported by ailing individuals themselves. Other persons with mental illness may show somatization disorder, where symptoms may not always be traceable to a physical cause but may nevertheless cause pain and/or neurologic or gastrointestinal disorders, symptoms that are real even though not directly related to the actual problem. Thus, descriptions of the symptoms related to mental illness may often make no sense within a Western interpretation. For example, Vietnamese patients have reported "feeling tired in the chest" when in fact they are referring to feelings of hopelessness, depression, and mental exhaustion [11]. Such symptoms may require translation and interpretation.

1.4.2 Issues of Language, Expression, and Communication

Among the more significant challenges for staff of health care facilities is that of the language barrier. The patient may not speak the native language, or speaks it without understanding specific terms related to health, disease, and medicine, or speaks it without understanding nuance. Language barriers present significant risk for adverse outcomes, with effects on health, safety, and future access [18, 19]. The patient may misinterpret the diagnosis, especially if it is not consistent with his/her own interpretation; may not fully understand medical instructions; and/or may feel embarrassed by that lack of understanding. Translation is not always the answer—in Sweden in 2015, 17% of the population had a foreign background, and within that 17%, 150 different languages were spoken. No systematized translation efforts could accommodate such great need. Furthermore, refugees or undocumented individuals may not have access to traditional healthcare systems or may avoid them for fear of deportation, and therefore they may seek help only when emergencies arise, a time when full "intercultural" services may be less available, yet a time when clear communication is more crucial than ever. Some studies suggest that under conditions of illness and emergency, an individual's ability to communicate decreases even further.

Even under less dire circumstances, treatment is affected by what the patient chooses to disclose to the practitioner [20], and the content of much of this discourse is culturally driven: potentially shameful or embarrassing elements may be omitted or not explained in detail. Furthermore, not only might the patient's terminology be limited (e.g., where English may be one of the several official languages as occurs in former colonies such as India, Nigeria, and Pakistan), but disclosure depends in part on what family members deem acceptable (and not dishonorable), with relevant factors including race, age, immigrant status, sex, language, and education of the patient, as well as the language, race, and sex of the practitioner.

The use of a language interpreter is one strategy that makes sense when a specific ethnic group dominates within a specific region (e.g., Spanish translation in US enclaves of California, Florida, regions of major cities, the Southwest, and so on). But where resettlement intentionally integrates ethnic and language groups into mainstream communities, for example, in many smaller municipalities in the USA or other countries, the problem of language interpretation is not so readily solved. Furthermore, in European countries where waves of refugees speaking many languages are entering the country (legally or illegally), translation services can only partially meet the needs of the system.

Furthermore, the general consensus is that language interpretation is *not* best served by those who may be most expedient, for example, family members—particularly husbands speaking on behalf of their wives. Using family members—parents, spouses, or offspring—may only compound the problem. Relatives may prevent objective and sincere representation of the problem and interfere with confidentiality protection—in the worst case scenarios the patient may actually become somewhat "invisible" in the process as the family interpreter takes center stage. A professional interpreter will, on the other hand, be trained to build bridges, maintain

an unbiased perspective, demonstrate emotional constancy, and even consider spatial/seating arrangements, placing the patient closest to the practitioner or maintaining equal distance from patient and practitioner.

Ideally, the interpreter would work side-by-side with the practitioner, understand medical and health care terminology, and be available for subsequent visits so as to ensure continuity. Seldom, of course, do community healthcare systems have resources to ensure such optimal circumstances. In some instances, having an interpreter who mirrors the ethnicity of the patient may help minimize apparent cultural differences between patient and practitioner, thereby leading to greater self-disclosure. Indeed, such interpreters can assist in interpreting non-verbal communication, including manner and tone, whether the culture is high touch vs. low touch, and the appropriateness of certain types of gestures [11]. However, interpreter–patient or patient–practitioner concordance can also lead to problems, for example, when the patient/interpreter/practitioner triad makes erroneous assumptions that cross-cultural issues have largely been addressed because of a presumed shared cultural background (consider a Latino patient visiting a Latino physician).

Assuming that communication is fairly open, to ensure accuracy, the practitioner should ask the patient (through the interpreter if necessary) to repeat back the key elements of the conversation along with any information and instructions in his/her own words. As simple as the task seems, the process can help ensure that the communication has been clear.

1.4.3 Relationship Between the Patient and Practitioner

For successful health care delivery, the practitioner and patient need a positive working relationship. Key to this relationship is a sense of trust [21, 22]. The development of trust depends partly on the perception of competence—that the practitioner has sufficient expertise to benefit the patient—*and* the perception of good will—that the practitioner will act only in a manner that serves the best interest of the patient.[1] Cooper [23] notes two aspects of this trust within the patient–practitioner relationship: (1) fiduciary trust, in which the power disparity between physician and patient assumes that physicians and their institutions will do the right thing with regard to providing effective medical care, and (2) trustworthiness, demonstrated through humanistic qualities such as compassion, altruism, empathy, honesty, and so on. Ultimately, patients want and need to be treated with dignity and respect [24], and such treatment is essential for developing trust.

The nature of the relationship between patient and practitioner weighs most heavily on the practitioner. The practitioner can promote a positive trusting relationship with the patient by recognizing the importance of cultural differences,

[1] You can imagine the issues of broken trust in health care systems that resulted when the US CIA deceptively used a vaccination program in Pakistan to learn the whereabouts of Osama bin Laden in 2011. As a result, legitimate vaccination programs in Pakistan suffered serious setbacks, with the effects still being felt today, nearly a decade later.

by taking the patient's problem seriously even when symptoms and explanations do not seem readily apparent or plausible, and by engaging in friendly and open dialog, sometimes difficult given the physician's time constraints and the patient's resource constraints.

The above approach is best characterized as "patient-centered care." And even though this approach is already the mainstay bedside manner for many physicians, its projection by the practitioner is even more critical when patient and physician share little common ground in terms of class, culture, ethnicity, religion, values, and biases [25]. The patient-centered approach, often characteristic of general practitioners, is perhaps even more important in medical situations requiring high technical skills, such as those in oncology or neurosurgery. Yet this approach is sometimes overshadowed in situations where technical skills and language pre-empt other aspects of patient–practitioner interaction.

Attempting to learn specific behaviors that convey respect is often an endless and futile task—this culture avoids eye contact, that one imparts decision-making to a family representative, another requires permission for physical contact from either the patient or a family member, and so on. Such tasks are further complicated as signs of respect undergo change as patients assimilate into a new culture. In contrast, adopting a patient-centered approach characterized by compassion, understanding, and care that is obvious to the patient and family generally leads to consistently greater patient satisfaction and better health outcomes [26]. The patient-centered approach, discussed further in Sect. 1.6, involves a number of broad principles that drive communication and interaction, as delineated in Box 1.2 [27].

A patient-centered approach never implies that the practitioner retreats from professional standards and principles of ethics. The concerns of the practitioner always need to be addressed, for example, obtaining complete and accurate information even when the patient/family is reluctant to share, conveying risk even when posing the possibility of patient misinterpretation, and ensuring compliance even when the patient's decision-makers may object to aspects of the treatment. However, treating patients as we ourselves would want to be treated during crisis or times of vulnerability encapsulates the essence of patient-centered care.

Box 1.2 Association of American Medical Colleges (AAMC) cross-cultural skills (see Epner paper [26])

- Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class
- Dealing with hostility/discomfort, as a result of cultural discord
- Eliciting a culturally valid social and medical history
- Communication, interaction, and interviewing skills
- Understanding language barriers and working with interpreters
- Negotiating and problem-solving skills
- Diagnosis, management, and patient-adherence skills leading to patient compliance

Finally, many practitioners have learned the lesson that in some cultures, a relationship with a patient (even when a mature adult) means having a relationship with his/her family. Elders in a family (often men/husbands) may decide when someone is sick, what the cause is, and who should be sought out for treatment [3]. They may also play an important role in deciding what treatment is acceptable or preferred for the patient. Parents may be particularly protective regarding the sexual health of their daughters. Thus, giving advice that is contrary to a family member's way of thinking (husband, elders, parents, etc.) may lead to non-compliance and ineffective outcomes. As a result, practitioners may need to seek out those family members responsible for decision-making, query them about their goals regarding the afflicted family member, and include them in the decision-making process when possible. When family members realize that they and the practitioner both share the common goal of doing what is best for the patient, the likelihood of achieving a desirable outcome is greatly enhanced.

1.5 Cultural Diversity and Sexual Medicine

As mentioned in Sect. 1.4, gender and sexuality constitute major areas of concern regarding cultural differences and health care [28, 29]. Sexual issues represent highly sensitive topics, but not just to patients. Recent analysis has suggested that a high percentage of general practitioners feel uncomfortable raising issues about sexuality during the typical office visit [30] and these findings do not take into account situations involving cultural differences between patient and practitioner. Imagine the discomfort for both practitioner and patient when a cultural divide adds to the lack of confidence and awkwardness of the conversation. Anthropologists learned early on that an understanding and sensitivity to cultural values was critical to effective efforts and policy-making in the field of sexual and reproductive health, as seen in attempts to encourage contraception through sterilization in India, a program that led to long-term distrust of family planning in a country having a strong pro-natalist orientation [31].

Cultural differences in sexuality—what is accepted, what is expected, and how these differ for men and women—are both significant and, in some domains, well documented. For example, in some Asian countries, sexual well-being falls short relative to other populations, on measures of sexual satisfaction, relationship functioning, and the importance of sex [32]. In many regions of the world, women's roles are not only rigidly defined, women themselves are often viewed as a weaker sex whose sexuality needs to be protected (and controlled) by men/husbands [33], or whose sexual desire needs to be thwarted through genital cutting. In still other cultures, men and manhood are associated with sexual aggression, competitiveness, and philandering [34, 35], a perspective that not only places great sexual pressure on men, but also places women at risk for sexual assault. In nearly all cultures, the inability to perform sexually in a manner consistent with sexual scripts creates anxiety, shame, and stigmatization.

In this section, we provide several snippets attesting to the kinds of challenges that arise when an individual's cultural perspective about sexuality is not fully aligned with the assumptions of the health care system or provider.

- The social construction of what it means to be a "couple" is deeply embedded in culture. In Western culture, a couple is typically considered the conjugal/sexual pairing that forms the basic family unit [36, 37]. But in various Western subcultures (e.g., transgender) [38] and other parts of the world (e.g., where polygamy is accepted), the Western concept of "couple" may have little relevance. For this reason, the healthcare practitioner/clinician may need to explore the meaning of "coupledom" when issues of sexuality are encountered, including in some instances, how the couple relationship is related to the rest of the family.
- In research on cultural differences and health care in Latina women, both foreign and US born, sexual topics emerge as the most sensitive of all issues [20]. Most difficult are problems surrounding self-disclosure, and particular concern occurred when there were perceived differences in the culture, language, sex, age, and birthplace of the healthcare provider. Women indicated discomfort mentioning genital problems because they wanted to avoid examination, and they indicated they would even avoid reporting partner abuse for this same reason. Their level of disclosure was generally related to physicians' patient-centered communication style, and for these Latina women, this included the perception of caring, concern, and compassion on the part of the practitioner.
- Sexual health in many countries is taught through a Eurocentric/Western biomedical framework [39] that views humans as sexual agents within an individualistic society. For children born in one country whose parents have migrated to another, messages about sexuality at home may be radically different from those at school, from peers, or from the media; that is, the parents' culture and that of the host country conflict. Zimbabwean women—largely the product of a distinctly African Christian culture—who have migrated to Australia had typically learned that their sexuality provided a means for pleasing one's (future) husband and that their role as women involved being a gentle and obedient wife. Thus, a woman's sexuality in Zimbabwe was defined largely in terms of how it might benefit men. Discussions about sex were largely taboo, as sex was considered secretive and, once openly discussed, it lost its power. These Zimbabwean women struggled to communicate issues of sexual health to their own children in their host Australian culture, where communication about sexuality is a parental expectation, yet is counter to the African expectation that another family member assumes responsibility for sex education. Without other family members nearby, these women often deferred to Church-sponsored education in Australia, which typically espoused abstinence and sometimes circumvented discussions about contraception. The authors of this report noted the inadequacy of sex education materials and guidance in Australia for providing migrants with tools and strategies essential to navigating cross-cultural and intergenerational differences regarding discussions, expectations, and information about sexuality.

- In Australia and Canada, migrant and refugee women show low use of sexual and reproductive health services, and therefore are at significant risk for negative outcomes [40]. The low use is explained by these women's general lack of knowledge regarding available services, restrictions imposed in previous location/culture, and the assumption that such services for unmarried women are unneeded or inappropriate. Talking about sex is sometimes taboo for women from certain cultures, and therefore using sexual and reproductive health services places women in a compromising situation that requires them to engage in a forbidden (i.e., sinful) behavior. The consequences of avoidance of sexual and reproductive health services were significant. Some women lacked basic knowledge about sexuality, showing naiveté about menstruation (which was thus frightening or shocking), or menopause, viewing the latter as the result of illness. Women often had little say in or control over their own reproductive health. For example, cervical screening and HPV vaccination were sometimes seen as a threat to virginity, the use of contraception was often considered a family/husband decision, and women were not permitted to ask their husbands to be tested for an STI. Yet, within the safe space of the interview, many women showed interest in receiving information about sexual health, contraception, HIV testing, STI prevention, HPV vaccine, painful sex, educating their children, and even negotiating sex within their own marriages—as well as wanting to educate their husbands about many of these issues.
- Changes in gender role often present a major challenge, particularly for women, as non-natives transition from one set of cultural values to another. In an interview with Iranian-American women, Rashidian [41] noted their highly conflicted situations, as these women experience feelings of disloyalty to their culture and religion, along with guilt, self-doubting, and shame as they, with apprehension, want to explore and in some instances embrace an identity more accepted in the Western tradition. They often continue to experience strong pressures from their family/husband to retain the traditional female role of their native culture, sometimes feeling as controlled in the USA as in Iran, by both family and tradition. For these women, who felt a sense of entrapment by patriarchal rules which placed on them the burden of upholding the family's honor, life was often viewed as a balance between being the passive, resigned, and family-dependent self of the old world and the independent, assertive, professional, and competitive self in the new culture once outside the Iranian-American community.
- Male circumcision and female genital cutting are areas where strong cultural differences occur, and where even Western medical experts disagree, at least regarding circumcision. This topic, discussed in detail in Chap. 17 of this book, demonstrates quite persuasively the power of culture in shaping medical practice [42, 43]. Female genital cutting shares some common roots with circumcision in boys, although the devaluation (or worse, barring) of female sexual pleasure has also served as a rationalization for female genital cutting in strong patriarchal societies. In such social systems, not only was control of women's sex lives by men considered standard procedure, but the clitoris was recognized as unnecessary for successful reproduction in women [44]. In some cases male

circumcision has been justified on the basis of good hygiene (a benefit) with little or no cost, as it does not interfere with male functioning in terms of orgasm and ejaculation. In contrast female cutting can interfere with female orgasm (presumably a high cost to the woman, but not necessarily the woman's partner) with no obvious benefit. The topic of female genital cutting has a plurality of perspectives, for example, with not all women who have experienced genital cutting reporting negative effects [16, 42]. Contentiousness occurs because some believe that different standards and scrutiny are applied to male circumcision vs female genital cutting, without objective consideration of the data—which, as might be expected, both sides seem to claim. For further discussion of the issues, refer to Chaps. 14 and 19.

The above issues/studies highlight the need to broaden and deepen our understanding of cultural diversity as it relates to the practice of sexual medicine. Not only do differences occur across cultures and religions, but different approaches and values are entrenched within similar cultures (as seen with male circumcision). And within nearly every culture—whether overt or hidden—various *sexual* subcultures exist. For example, within the USA, many alternative and non-traditional sexualities are found among those seeking health care, including those who subscribe to open marriage, consensual non-monogamy, polyamory, kink, transgender identification, or other less conventional behaviors [45]. Thus, assumptions regarding sexuality sometimes held by the practitioner may have little connection to the assumptions of sexuality of those seeking help.

A number of journals already attend to cultural differences related to sexuality, *Culture, Health, and Sexuality* perhaps being the most clearly identified by title. However, the translation of reported differences into clinic settings and practice is often not the focus of these reports. The goal of this book is (1) to bring an awareness of cultural differences to the practicing health care provider in sexual medicine, and (2) to demonstrate how such differences can be relevant to the health care and treatment of clients having sexual issues.

1.6 Developing Cultural Competence in Medical Practice

Many articles, reports, and programs have addressed the issue of developing cultural competence among health care practitioners in the clinic [46, 47], a trend initiated half a century ago by Kleinman's [2] list of suggested questions that every practitioner should ask the patient (Box 1.1). Since then, many sages, experts, and writers have offered advice regarding ways to handle situations involving cultural disparities between patient and practitioner.

For example, Juckett [11] identifies the need to possess knowledge, awareness, and respect for other cultures, as opposed to taking an ethnocentric stance where one assumes the superiority of the methods and values of one's own culture. Misra-Hebert [12] cautions that it is important for physicians to be cognizant of their own biases; for example, Western culture operates on a number of culturally based assumptions regarding health care and clinic interactions such as the expendability

of privacy in the doctor's office; the value of being forthright about disease, prognosis, and treatment; and the emphasis on individualism and control of our destinies—placing responsibility on the patient for actions that contribute to his/her recovery. Taking another approach and realizing it as the exception to the rule, Deagle [13] lauds the idea of practitioners living within the communities they treat so as to enable "careful observation of cues, becoming culturally aware as a means to discovering that we too have a folklore of culture with myths and metaphors that are often no more valid or real than the folklore of other cultures." Others speak to being attentive to our own situatedness [34], although some, wanting to add balance to the conversation, warn that although multiculturalism requires respect for cultural diversity and that we approach other cultures non-judgmentally [48, 49], tolerance does not necessarily imply acceptance of their values. Stated more broadly, the fundamental underlying principles of good medical practice, particularly those involving basic human rights, should not be compromised. While the concept of human rights (and perhaps more controversially, women's reproductive rights) "may have originated in the West, this does not make it innately Western" [50] and when specific religious traditions or cultures deny such rights, they undermine fundamental principles of Western medicine.

Most practitioners understand that family medicine requires appreciation of the psychosocial aspects of health [3, 11]. So, what is it exactly that health care professionals need to know or should do in order to become culturally competent? Should the practitioner develop awareness of the verbal and non-verbal idiosyncrasies of various major cultures, learn to avoid certain gestures, understand differences in personal space requirements, or develop awareness of the differing interpretations of direct eye contact? Most would argue: "not necessarily." The basics of working across cultures are perhaps best learned not by exhaustive review of attitudes and behaviors but by reflection, both on one's self and on patients' lives, beliefs, and actions [51]—in other words, the first tenet is that there is need to be intentional about the process and not merely assume one can improvise his/her way through the patient–practitioner discourse.

Programs devised to improve cross-cultural interaction stress a variety of approaches. As an example, the LEARN program (Box 1.3) delineates a sequence of steps that can be used to guide the practitioner through a clinical session with the patient. Most such programs recognize the tripartite process of increasing knowledge, adopting a particular attitude, and skill-building, with the more prominent elements of most programs being those of attitude and skill-building [24].

Box 1.3 LEARN Program [42]

- *L*isten with sympathy and understanding to the patient's perception of the problem
- *E*xplain your perceptions of the problem
- *A*cknowledge and discuss the differences and similarities
- *R*ecommend treatment
- *N*egotiate treatment

Attitude is perhaps best characterized by practicing, adopting, and refining—as mentioned previously—a patient-centered approach, even in situations demanding high technical competence where person-based skills may seem less important. *Skill-building* generally focuses on verbal and non-verbal communication strategies with the patient. In other words, being aware of the need to be culturally sensitive (rather than trying to learn the details of many different cultures), paired with a person-centered attitude and effective verbal and non-verbal communication skills, is often sufficient to ensure positive practitioner–patient interactions in cross-cultural settings.

Fortunately, practitioner training programs that emphasize these two aspects of patient interaction—attitude and communication—appear quite effective in improving *patient satisfaction*, particularly when all healthcare staff are trained, including receptionists, practicing staff, assistants, and so on [19]. No particular characteristics of various training programs have stood out as being most effective, that is, whether long vs short, experiential or not, or specific vs general cultural information.

Several other aspects of training programs have been noted. First, although patient satisfaction has generally improved with practitioner cross-cultural training, actual patient health outcomes are not consistently assessed, making it nearly impossible to evaluate the overall health benefits of such programs. Second, a concerted approach to cross-cultural medicine is likely to require resources/funding, and sometimes such resources (e.g., as that necessary for interpreters) are not easy to secure.

1.7 Conclusion

The practice of medicine emphasizes the importance of cross-cultural competency, and sexual medicine could benefit from an understanding of how cultural differences can impact the sexual health and well-being of individuals. Many resources are available to clinicians to help them develop a positive and effective attitude in the treatment of patients from disparate cultures—an example of one such resource is the *Pocket Guide of Culturally Competent Communication* (Fig. 1.1) [51]. Specific to sexual medicine, the chapters of this book address cultural differences related to gender, sexual identity, and sexual response that have implications for clinical practice.

1.8 Resources

Additional resources are readily available for developing cross-cultural skills, including programs, tip sheets, and online training modules. Visiting one of the following websites may provide a helpful starting point:

https://www.ceh.org.au/cultural-competence-communication/.

http://sph.umd.edu/department/epib/cross-cultural-clinical-skills.

https://pdfs.semanticscholar.org/8140/4335016cdc110d3b75f058dfe41a412d247c.pdf?_ga=2.261315341.1055063370.1548449477-136238883.1548449477.

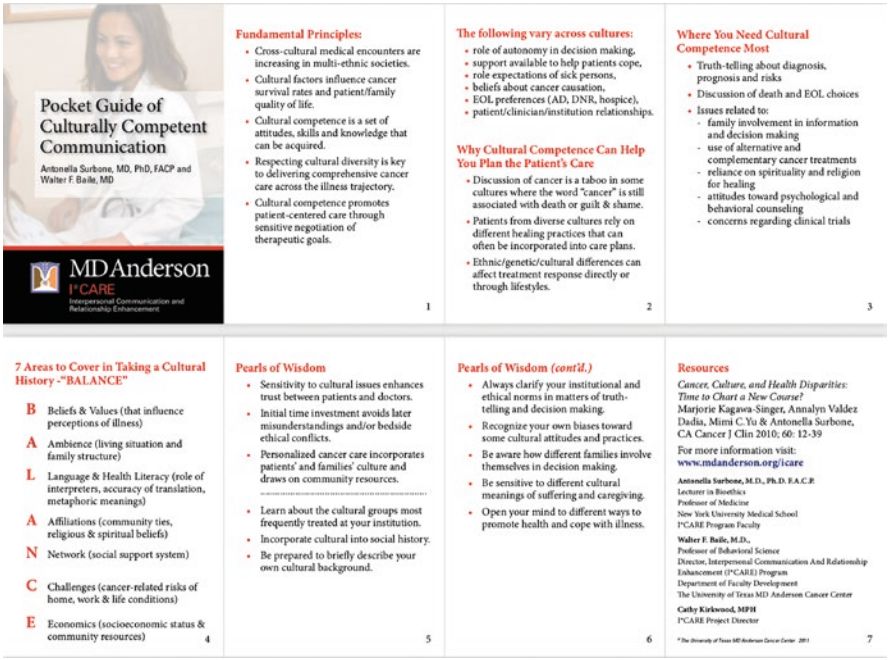

Fig. 1.1 Example of pocket guide used at MD Anderson. Reprinted with permission of the author WFB

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Role of Medical Anthropology in Understanding Cultural Differences in Sexuality

2

Emily Wentzell and Christine Labuski

2.1 Using Anthropology to Understand Sexual Health

If a patient reports having trouble with sex, do your follow-up questions reflect your own cultural and personal assumptions? For instance, do you assume that "trouble" means a biomechanical problem, like pain or erectile dysfunction? Or that "sex" signifies vaginal–penile penetrative intercourse? If so, you would not be alone. Patients report that they want to talk about sex with their clinicians but most healthcare providers are inadequately prepared to do so [1]. This lack of preparation includes a dearth of education about how to talk with patients about sexual issues, and an even greater lack of training regarding how physicians' and patients' ideas about what kinds of sex are desirable or "normal" are influenced by their cultural contexts, from country of origin to the culture of medicine itself. In this chapter, we explain how practitioners can use insights from anthropological studies of medicine, gender, and sexuality to provide more responsive sexual health care.

Anthropology is the study of human behavior and biology in relationship to changing time and place. What makes this a coherent analytic approach, rather than the study of everything, is the specific method of anthropological analysis. Anthropologists understand relationships between human behavior, biology, and context by using two main approaches. They think holistically, accounting for relationships between macro- and microlevel factors, from culture and economics to family interrelationships, to understand people in context. They also think comparatively, for example, comparing behavior across cultures so as to reveal the

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contextual nature of apparent "universals." Further, this discipline focuses on studying human variation in all its forms, and thus understands sex, gender, and sexuality to contain as much variation as any other human attribute or behavior. Anthropologists argue that some of anthropology's most basic tools—the centering of human variation and difference; prioritizing curiosity over judgment; relying on trust and qualitative methods of research; and denaturalizing sexual behavior by enumerating the social construction of norms—can be readily translated into clinical behaviors that facilitate better communication with patients about sex and sexuality.

Medicine focuses on identifying and treating pathological variation in people's bodies and behaviors. The medical approach can be supremely useful for treating disease. Yet the ideology of a single "normal" kind of body—or, by extension, one "healthy" kind of sexuality—can have negative consequences if applied uncritically. What counts as normal, healthy, and ideal sexual function and behavior may vary immensely across time and place [2]. For instance, people in some places and times have been required to marry and reproduce with their cousins, while in other places this practice is taboo [3]. While marriage is often thought of as formalizing "natural" kinds of gender and sexuality, the sexes and numbers of people involved in marriage and expectations of what marriage actually is (from a reproductive partnership, to the economic relationship of family lineages, to love and intimacy) have varied across place and time and reflect context-specific economic, political, and religious concerns [4]. Similarly, some cultures view participation in sex as required or normative for adults (however variously defined), while others value celibacy for those of certain ages or in particular social roles, like religious renunciates [5]. Same-sex sexual activity is in some cases unremarkable, in some cases stigmatized, and in still other cases seen as required in some situations but inappropriate in others [6]. The idea that who a person has sex with reflects a fixed element of that person's identity is itself historically quite new, and the categories used to discuss this identity, from heterosexual to pansexual, are constantly evolving and culturally specific [7].

Expectations of sexuality reflect the gender norms of a specific time and place. Gender norms are societies' particular ideas about the fundamental natures of women, men, and in many cases additional categories of people (from hijras in India to muxe in Zapotec Mexico, to, emergently, non-binary people in the USA) [8]. However, wide variation in these norms across time and place reveals gender to be a socially constructed and context-specific set of practices rather than a universal essence [9]. Social scientists thus define gender as the cultural practice of living out local expectations related to physical sex, typically defined via a "series of somatic characteristics [including] chromosomes, gonads, genitals, and secondary sex characteristics" ([10], p. 5). Sex is often understood as being either female or male, but a range of intersex conditions show that sexual categories are not so neatly dichotomized [11]; in this context, gender can be understood as an interpretation of one's sexed body or what Kessler and McKenna refer to as "cultural genitalia" ([12], p. 154). Anthropologists understand both sex and gender to be mediated by human biology, but in a plastic rather than deterministic way (since human biology itself, like hormone levels, varies widely with environment (e.g., [13])). Understanding

gender as an individual response to cultural expectations, which comes to feel natural, is crucial for responsive sexual medicine. As clearly demonstrated by the ongoing fight to define same-sex sexuality as normal behavior and desire rather than as a medical or psychiatric disorder [14], conflating one's current cultural ideologies of behavior with biological normalcy and health at best reduces medicine's efficacy and at worst makes it a source of iatrogenic harm. As the trauma and abuse inflicted in the name of "conversion therapy" for homosexuality shows [15], health care providers may do serious harm if they understand people's differences as biological pathology to be treated through medical means.

Here, we discuss how healthcare providers can employ anthropological insights in order to responsively treat sexual problems without causing harm. Medical anthropology investigates health and healing as context-specific, bio-psycho-social phenomena, by applying the holistic and comparative lenses discussed above. Medical anthropologists often begin by "denaturalizing"—identifying as culturally and environmentally contingent—issues that the medicine of a specific place and time might erroneously define universally as "natural," "normal," or "pathological." Anthropologists do this by attending to medical practices as themselves parts of culture. For instance, medical encounters are influenced by hierarchies defined by symbols like white coats, shaped by local economic systems that affect health and access to care, and reflective of the class, racial, and gender inequalities of the broader society, as well as its ideals for behavior and bodies [16]. Such enculturation is often called the "hidden curriculum" of medical education [17]. Thus, even within the standard practice of medicine, what people view as normal variation versus pathology, how they think illness should be treated, and how forms of social and economic stratification outside the clinic influence these decisions lead to wide variations in medical practice across contexts. One example is whether plastic surgery in response to failure to meet context-specific beauty norms is seen as a want versus medical need [18]. Both providers' and patients' behavior can only be fully understood if cultural assumptions are denaturalized and health interactions understood holistically (apparent "noncompliance" is a clear example of this (e.g., [19])).

That providers' and patients' behaviors, people's bodies, and medical ideas of health and normalcy are context-contingent might be a familiar insight to some medical practitioners. For instance, anthropological insistence that culture fundamentally influences people's ideas about sickness and healing is reflected in medical efforts toward "cultural competency." Unfortunately, these well-meaning efforts can lead to the use of reductive lists of stereotypes about patient behavior. They also tend to frame culture as something that patients have but providers do not, missing half the dynamics that shape medical interaction. Anthropologically inclined physicians have thus called for an expansion toward models of "cultural humility" [20] and "structural competency," which reveal how both cultures and broader economic and political structures influence illness, patient experience, provider behavior, and medical care [21, 22]. Providers also tend to think of "culture" as something that interferes with a person's understanding of an allegedly "objective" disease condition, such as diabetes or cancer, which can marginalize other ways of understanding illness and bodily distress. This approach is especially worrisome regarding gender

and sexuality, where few universal realities exist [23]. Here, we demonstrate how medical anthropologists have used in-depth qualitative research to understand clinical encounters as sets of relationships, both between people from specific cultural backgrounds (from country of origin to the culture instilled by one's medical training) and between those participants and broader economic, political, and institutional structures.

To do so, we discuss findings from two research projects on sexual medicine in the Americas. We are cultural medical anthropologists, and Labuski is also a former nurse practitioner who worked for 15 years in sexual and gynecological medicine. Our research investigates how cultural gender expectations influence patients' and providers' perceptions of and responses to sexual health problems. We specifically ask how broader cultural, structural, and interpersonal contexts influence what people define medically as sexual dysfunction, and how they seek to treat it. While anthropologists answer holistic questions about human experience and development using a range of methods, from qualitative inquiry to DNA analysis, we focus here on clinical ethnography. This methodology is characterized by long-term immersion in the actual research setting in which the anthropologist performs "participant observation" to understand not just what people say, but also what they do, how it feels to them, and how specific experiences relate complexly to social and material context. We analyze our findings from the denaturalizing assumption that everything we experience, whether defined by participants as social or biological, is context-contingent rather than universal. Specifically, we present findings from a study of older men's experiences of decreasing erectile function in Mexico, and a study of women's treatment for vulvar pain in the USA, to illustrate the ways that contexts, including norms of sexuality and gender, economic setting, and medical practice, influence how people define and treat sexual dysfunction. Through this analysis, we (1) demonstrate that medical norms for sexual function and behavior are context-specific as opposed to universal or "natural" and (2) show clinicians how they might incorporate this kind of inquiry into their practice in order to meet patients' needs without doing harm. We then offer several guidelines for better understanding context-specific variation of people's sexual norms and desires so as to improve clinical practice.

2.2 ED Versus Natural Aging in Mexico

Drugs for erectile dysfunction (ED) have been global blockbusters since the 1998 introduction of Viagra. By enabling men to maintain erectile function despite aging or illness, they also enable the performance of specific forms of manly sexuality centered on youth, virility, and strength. They can thus serve as "masculinity pills," helping men not just to have penetrative sex but to live out forms of manliness which require it [24, 25]. They especially serve as anti-aging treatments, enabling men to live out forms of sexuality associated with youth [26].

Based on cultural stereotypes—including those held by many people in Mexico—Mexican men would seem like an ideal market for ED drugs. Since the 1950s,

Mexican popular culture has featured the idea of "machismo," the notion that Mexican men, as the ancestors of coercive unions between conquistadores and indigenous women, are innately predisposed to womanizing and emotional closure. The idea of machismo comes from literature rather than social scientific evidence, and has been widely criticized both as a racist stereotype and as a bad way to be a man [27, 28]. Nevertheless, Mexican men often see machismo as an inherited fault which they must work against in order to be good people [29, 30]. This view reflects the emergence, over the past several decades, of ideals of masculinity that have changed alongside increasing emphasis on gender equality and global prominence of the ideal of marriage as a site of faithful, romantic intimacy rather than just economic and social reproduction [31]. While in the recent past a "good" man not only provided economically for his family but also demonstrated virility through extramarital sexuality, today ideal masculinity in Mexico includes emotional intimacy with family and monogamy along with responsible provisioning and parenting [32]. Despite easy access to and widespread knowledge about ED drugs in Mexico, Wentzell found that social changes and expectations made ED drugs quite unattractive for a subset of Mexican men, specifically because of criticism of the macho stereotype.

To understand men's experiences of decreasing erectile function, Wentzell did observation and in-depth patient interviews at a hospital-based urology clinic in the central Mexican city of Cuernavaca. This hospital was part of the Mexican Social Security System (*Instituto Mexicano del Seguro Social*, or IMSS), which provides cost-free care to privately employed workers and their dependents. Since services are comprehensive but waits can be long, wealthier patients often see private physicians for lower cost treatments, meaning that the majority of IMSS patients were working class. Men at this clinic were generally seeking treatment for prostate or kidney problems; urologists asked patients they thought might also be experiencing decreasing erectile function if they wanted to talk with a researcher. Most did, and Wentzell interviewed over 250 men, about 50 together with their wives; these men were mostly in their 50s and 60s. A detailed discussion of study methods, ethics, and findings can be found elsewhere [33].

Although 70% of participants reported a decrease in erectile function, and all were in the midst of accessing medical care for other urologic issues, only 11% even considered medical treatment for this change. Most simply did not see decreasing erectile function as a biological pathology. Instead, they understood it to be a "natural" part of aging. For instance, a 55-year-old delivery driver described decreasing erectile function as a normal outcome of aging and hard work. He said, "My work is a little rough, heavy. I carry a lot, so I feel a little tiredness. Now, I can't have as much sex as before. This is normal." Similarly, a retired electrician in his late 60s equated cessation of sex with the end of his work life, joking, "It's part of being retired—I can't work anymore!"

Men described decreasing erectile function not just as an aspect of normal aging, but as an aid for aging in socially appropriate ways. Many discussed the expectation that respectable older men shifted their focus toward the domestic sphere in a "second stage" of life. For instance, a 56-year-old about to retire from the public health

service said he would now "dedicate myself to my wife, the house, gardening, caring for the grandchildren—the Mexican classic." Virility was antithetical to this vision of later-life domesticity. A 75-year-old retired factory worker explained, "Erectile dysfunction isn't important. When I was young, it would have been, but not now."

Most significantly, men of this generation had been raised to think that good men provided economically but pursued sex outside their marriage. As ideals of masculinity and marriage changed over their life course, they were often criticized by their wives or adult children. Thus, many saw decreased erectile function as an aid for overcoming innate urges toward infidelity, which would then enable them to live out current ideals of faithful manliness. For instance, a 67-year-old retiree criticized the machismo view but said that in his youth, bodily urges would bring out macho traits. He offered the example that as a young man, "I saw a pretty prostitute, with a really nice body. In cases like that, the macho comes out of us. So, I slept with her." However, he said that as an older man with lessening sexual response, he was able to resist such urges and pursue a more faithful and intimate relationship with his wife. Here we see not only that erectile function is not an "objective" medical condition for which a universal prescription of a vasodilator is the treatment, but also that sexual norms, expectations, and "truths" can change over time, in this case, over the course of just one couple's lives. Clinicians should keep such perspectives in mind as they assess and manage clients sexuality concerns.

Men's wives often encouraged them to make these changes, offering assurances that decreasing erectile function was "natural" and "normal" and that they were not upset about having less or no sex. For example, when a 68-year-old laborer said that he had recently been experiencing less firm erections and that he was sad because he believed his wife "doesn't like" the change, she corrected him by saying, "It wasn't the same, but it's not serious, it happens with age and health problems." In this way, partners normalized men's changing sexual function.

Given the idea of decreasing sexual function as both natural and socially beneficial, participants often believed ED drugs to be so inappropriate that they must cause physical harm. Men often discussed such interventions as disrupting the natural bodily and behavioral slowing of aging. For instance, a 78-year-old food vendor stated that ED drugs "accelerate you, to your death. Many friends have told me, they will accelerate you a lot, then you'll collapse, that stuff will kill you."

Anthropological observation in the clinic revealed that men's health care providers had no desire or incentive to convince them to view decreased erectile function as a pathology rather than as a natural aspect of aging. They shared the idea that good older men should live out the "Mexican classic" shift articulated by their patients. Structural and class issues also mattered. IMSS physicians also had private practices where they commonly prescribed ED drugs to younger and wealthier older patients. While the IMSS was supposed to provide free ED drugs, the reality of strained resources meant that the hospital pharmacy did not stock them. Thus, working-class patients would have had to pay out of pocket. There was simply no reason for IMSS physicians to convince patients and their wives that men should be using drugs to facilitate penetrative sex in older age.

These findings show that the same biological changes can be understood very differently in different contexts. Decreasing erectile function is a medical pathology for men who wish to perform penetrative sexuality—and thus, retain virile and youthful masculinity—in later life. Conversely, it was a natural and socially beneficial aspect of aging for the men who used it as an aid for living out the anti-macho and age-appropriate forms of masculinity enabling them to be good men in the present day. Health care providers must thus take into account what their patients understand as natural versus pathological change, rather than relying on their own assumptions. The lesson from this case is not that healthcare providers should refrain from offering ED drugs to patients. Rather, it is that clinicians need to understand that they provide care in a cultural context, parts of which they share with their patients and parts of which they do not.

2.3 Vulvar Disease

Much of what led Labuski to move from clinical practice to cultural anthropology was her conclusion that gender and sexuality were far more complicated than her medical training had led her to believe. This conclusion became especially evident when she practiced in feminist and LGBTQ health clinics, where it was difficult to untangle her patients' health concerns from the cultural norms that shaped their sexual identities (e.g., lesbian) and practices (e.g., having an abortion). Working in these environments also made several cultural patterns clear, one of which was the profound embarrassment that many patients evinced when talking about their vulvas and vaginas. This experience led Labuski to wonder how a person with vulvar symptoms (such as pain) would seek help and care, and how both patient and provider would navigate the cultural constraints against talking too frankly about "down there."

Though terms like "va-jay-jay" and "vag" have become more common over the past decade, it is still fairly taboo for a woman in contemporary US society to explicitly discuss her genitals, a reality that is both produced and compounded by the plethora of "dirty" jokes involving degrading words and images for vulvas and vaginas. One of the central dilemmas that informed Labuski's research, then, was how a person could be both a good *woman* (who does not talk about her vulva) and a good vulvar pain *patient* (who compliantly describes her symptoms to a clinician). From a feminist, anthropological, and sexuality perspective, gender norms play an enormous role in how people with vulvar pain interpret and act on their symptoms: from the normalization of a certain amount of pain with vaginal–penile coitus, to the belief that women should be sexually compliant in heteronormative situations and remain "private" about their genitals. Operating on these assumptions, the vulvar pain patients in Labuski's study struggled to utter the words they needed to describe their pain and acquire treatment for it.

Labuski conducted 14 months of anthropological fieldwork in a US vulvar pain clinic. Vulvar pain—also called *vestibulodynia, vulvodynia, or vestibulitis*—is characterized by an inability to tolerate genital contact; lifetime prevalence estimates

range from 10 to 28% [34] in the general US population.[1] In her research, Labuski observed the physician visits of over 100 women. She conducted in-depth interviews with 45 of these patients and observed the physical therapy sessions and surgeries of a smaller subset. She also attended a local support group and the first national conference on vulvar pain conditions (a detailed discussion of study methods, ethics, and findings can be found elsewhere [37]). Ethnographic attention to these patients found them to be sexually "shut down" in relation to their symptoms. Afraid of the pain, they avoided sexual overtures from their partners and lamented their lack of connection with friends and family members who sometimes wanted to talk about the pleasurable aspects of their sex lives. They were also profoundly alienated from their genitals—as both "unknown" body parts and as a source of life-altering pain. Having come to this project via her clinical experience, Labuski found that this alienation was actually an extension of how many women, even those without vulvar pain, relate to their genitals.

In studying clinicians who worked in a vulvar specialty clinic, Labuski noted how they had to behave differently from other clinicians; they had to talk explicitly about their patients' genitalia and refrain from making assumptions about how their patients used and understood their vulvas during sexual encounters. Still, heteronormativity pervaded the clinic and women were sometimes encouraged to use topical anesthetics to engage in penetrative intercourse, an activity that had the potential to produce several days' worth of symptoms for the woman. What was missing from the patient's clinic experience were discussions where non-penetrative sex was central and normalized, thus leaving patients without explicit resources about how they could be good *women* while abstaining from or deferring vaginal–penile intercourse. Women's investments in enacting a compliant feminized sexuality remained undisturbed and subsequently pervaded the kinds of goals they established at the clinic. Labuski also found that vulvar pain was mainly a white affliction, being diagnosed far less frequently in women of color. This disparity evinces another dynamic that anthropology is keen to describe: that in addition to gendered frameworks, clinicians often operate through racializing ones. Black women do experience vulvar pain but are often separated from white women in the diagnostic process through screening questions that emerge from assumptions about race [38].

These difficult realities were compounded by the paucity of clinicians who specialize in vulvar pain; patients came to the specialty clinic from all over the country. Confronting—and disrupting—the intransigence of heteronormative sexual

[1] Vulvodynia is currently classified as either provoked or unprovoked, with the former experienced solely on contact with the vulvar vestibule. The pain of provoked vestibulodynia is situational and specifically located, while unprovoked vulvar pain is more anatomically diffuse, making it harder to predict and manage. Women with provoked pain report that genital contact has always been painful, whereas women with the unprovoked variety have often had non-painful and even satisfying genital-sexual experiences before the onset of their symptoms. Identified risk factors include HPV, chronic candidiasis, concomitant autoimmune conditions, a history of difficult tampon use, and a childhood history of violence or fear [35]. Treatments for both conditions include antidepressants, dietary and skin-based regimens, and physical therapy. Provoked vulvar pain might also be managed with surgery [36].

narratives that prioritize vaginal–penile penetration and that compound the lived experience of vulvar pain requires a kind of "sex work" that is both laborious and rare. Health care providers frequently do not have the tools to collect adequate sexual histories from their patients [39, 40] and seldom possess the social scientific skills to analyze how those individual histories do or don't link up with broader social structures and practices through which genitalia—vulvas and vaginas especially—are often demeaned. According to a report from the National Institutes of Health, new clinicians are averse to the "complexity of [vulvar pain] and the diversity of the disciplines required for significant scientific progress" ([35], p. 7). Painful vulvas are described as a literal drag—on clinicians' time, energy, ingenuity, and, perhaps most stubbornly, on professional identities that are accustomed to making measurable differences in patients' lives. These clinical attitudes are shaped by the same cultural processes that shape vulvar alienation; they are two sides of the same societal coin.

2.4 Conclusion and Guidelines

As medical anthropologists who study sexual medicine, we are particularly enthusiastic about making the connection between these two fields evident and explaining how these connections can enhance clinical practice. As scholars of humans and human variation, anthropologists of sexual medicine seek to demonstrate and interpret the widest possible range of beliefs and behaviors regarding how people manage their bodies in relationship to their sexual desires. We are also interested in denaturalizing those desires, behaviors, and beliefs, not to trivialize them, but to demonstrate that they are context-contingent and mutable. As we mentioned at the beginning of this chapter, people want to talk about sex with their health care providers, but clinicians are often not adequately trained to collect sexual histories and/or respond to their patients' sexual concerns. For example, the timeframe for diagnosing vulvar pain can be up to 5 years, in part because of the mismatch between patients who report non-vulvar specific "pain with sex" and clinicians' lack of expertise in asking pertinent follow-up questions. In stark and noteworthy contrast, the timeframe for an ED diagnosis in the USA can be as little as 30 min, reflecting measurable gendered differences in how sexual problems are perceived and managed. Clinicians have a ripe opportunity to design more inclusive medical history questions and treatment plans by drawing on the anthropological insights presented here, that is, that culture influences providers' assumptions as well as patients' problems and that people's experiences can be better understood by centering rather than marginalizing human variation in sexuality and sexual behaviors.

Though clinicians are trained to understand illness and treatment in objective terms (and to view themselves as neutrally positioned diagnosticians and deliverers of care), they should also remember that they are as culturally situated as their patients. A cursory reading of cross-cultural and/or historical health care practices demonstrates that collecting medical histories is often enhanced by tailored and patient-specific exchanges (e.g., open-ended questions). Purportedly objective

history forms that constrain patient experience to a limited number of pre-determined choices (which, in the case of sexuality, are often unnecessarily binarized) reduce the complexity of peoples' lives and have led to the exclusion and pathologization of numerous groups by medical experts. Clinicians' attitudes about sex, gender, and sexuality are influenced by factors that are personal (e.g., religion and family-of-origin) and social-structural, such as the healthcare system as well as current laws and policies. Working assumptions can also be acquired through mentoring and training environments, and clinicians should take care to challenge norms and customs that may cause harm to vulnerable patients.

Clinicians can cultivate what anthropologists call a "reflexive" approach to these issues, by thinking about the ways that their own ideas and actions have been shaped by particular cultural or structural influences and settings. For example, in the case of vulvar pain, insurance companies often do not cover the cost of surgery based on the assumption that women can engage in vaginal–penile intercourse even if it hurts. This assumption is not only dangerous for women with pain (and for the spouses who "learn" that painful sex is okay), but for all the subsequent patients seen by a clinician who adopts such a perspective. Clinicians who think critically about both the cultural assumptions behind the idea that women should endure painful sex, and the way insurance company policies serve as a structural force that shapes providers' practices and beliefs, can avoid perpetuating this problem. Similarly, a provider who unquestioningly accepts the script that men should continue youthful-style, penetrative sexuality into older age might diagnose "erectile dysfunction" and prescribe ED drugs or testosterone in cases where men and their partners are actually content with changes to their bodies and sex lives resulting from aging. One way to cultivate this reflexivity (and ability to challenge norms) is to adopt an anthropological sensibility, that is, to work from a position of curiosity rather than certainty, and to actively wonder why certain rules and/or norms are in place. Rather than *assuming* what patients want, we encourage providers to instead *ask*. Clinicians can institute practices, as suggested in the following paragraphs that draw from these insights in immediate and longer term ways.

- First and foremost, adopting a stance that assumes *less* rather than more—about patients, their behaviors, and what constitutes "normal"—goes a long way toward making room for variation among one's patients. Being curious and "diagnostic" *before and alongside* being judgmental and "prognostic" can enable more appropriate assessment and treatment of patients' actual needs. When a patient says they are queer, for example, what might that mean regarding their gender identity and sexual practices? As a health care provider, I should ask what *don't* I know about this term and what should I not assume, particularly regarding health or medical consequences that the patient or I might be concerned about? Do I have a place on my intake form for patients to identify as queer? How could I revise these forms to signal that I care and want to know more about patients' gender and sexual concerns?
- To further strengthen reflexive thinking skills, we recommend reading the social science literature about sexuality. A number of journals are written with clinical

audiences in mind (see Box 2.1 for suggestions), and often provide helpful "how-to's" for acknowledging and managing the complex nature of sex, gender, and sexuality in practice. Busy clinicians might limit their engagement with this literature to the kinds of problems that they routinely see in their own practice.

- Finally, health care practitioners need to be prepared to encounter resistance from colleagues as they accumulate new culturally sensitive practices and shift their perspectives. They should learn a few phrases that communicate how and why they find a medical anthropological approach useful, important, and/or meaningful for their practice and patients. Understanding that medical environments and practice often promote uniform perspectives over diverse perspectives can be helpful in this endeavor.

Box 2.1 Useful Journals

The journals below are useful resources for clinicians seeking to incorporate social scientific insights into their medical practice. Using an automated system like Google Scholar alerts or Mendeley, or subscribing to table of contents updates from these journals, is a good way to get automatic notifications of relevant articles.

Culture, Health and Sexuality
The Journal of Sex Research
Medical Anthropology Quarterly
Sexualities
Social Health and Illness
Social Science and Medicine
Social Theory and Health

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Part II

Sexual Issues, Identity, and Challenges: Editor's Notes

This section deals with sexual identities and variations in both Western culture and worldwide. In Chap. 3, Sindhuja describes the evolving situation in India—influenced by aboriginal and colonial pasts—where a culture steeped in traditional views of sexuality is having to face rapid changes in demographic, economic, and social conditions. She sketches out the current sexual health situation in India, and probes issues surrounding LGBTQ, gender perceptions of sexuality and their connection to sexual violence, and recent laws and regulations that have brought change (along with resistance) to policies governing sexual practices. She also discusses sexual dysfunction in India and offers recommendations to professionals regarding culturally sensitive issues that must be addressed in clinical interactions.

Chapters 4 and 7 both deal with the LGBTQ scene, presenting an opportunity for healthcare professionals to develop a deeper understanding of such issues as articulated by professionals closely connected with these communities. In Chap. 4, Fuller presents LGBTQ as its own cultural variation, providing a contemporary perspective on the many variations of sexual identity and its related terminology. In addition, she discusses the challenges this community faces with respect to sexual healthcare, often the result of healthcare professionals' misconceptions about these groups. Fuller sees both practical implications for professionals and opportunity for inclusion regarding these often disenfranchised populations. In Chap. 7, Francis introduces us to the topic of sexual fluidity, and thoroughly explores its conceptualization, terminology, and patterns and pathways as related to culture, gender, and lifespan. In doing so, she enables medical practitioners to assume a proactive role in providing medical and social support for such individuals, "with the ultimate goal of ensuring that persons of all sexual identities are able to access competent and informed healthcare." Francis concludes with key takeaways and recommendations, and directs readers to additional resources to learn more about the topic.

In Chap. 5, Ciocca and colleagues guide us on a world tour of homo- and transphobia, showing how countries and geopolitical regions differ on these characteristics and demonstrating the bi-directional influences of religious, sociocultural, political, and legal factors. The authors analyze the effects of such differences on the

mental health of communities, and promote an activist perspective, noting that—now more than ever—… "researchers, activists, and enlightened politicians must consider and respect differences among cultures, civilizations, religions, and countries when dealing with gender issues, but they must also advocate for campaigns that safeguard the psychological and social health of LGBT individuals."

In Chap. 6, Colonnello and Jannini explore how traditional cultural values and folk beliefs among the Chinese may present challenges to those who practice Western medicine. In their highly descriptive narrative of various Chinese/Asian folklore and beliefs—ranging from the meaning of illness to the meaning of masculine, they demonstrate how traditional values may clash with assumptions underlying Western medical procedures. As an alternative, they provide a "systems" model of treatment that incorporates family, environment, gender, relationship, economy, etc. that better situates patients within their cultural milieu by adopting holistic perspectives that respect traditional values related to human sexual and reproductive health.

3 Socio-cultural Perspectives, Challenges, and Approaches to Sexual Health in the Indian Subcontinent

Sindhuja Giritharan

3.1 Sexuality in Indian Culture: Ancient to Modern

India—one of the most ancient civilizations in the world tracing back 8000 years—has evolved beyond barriers. Beholding ethnic and lingual variations and diverse demographic, religious and socioeconomic conditions, this civilization has its own set of versatile religious, moral, political, and sexual values. Unlike much of the rest of the world where sexuality is seen in contrast to religious morality, the idea of sexuality in India had traditionally been beautifully entwined with religious and scientific understanding. Yet, in the present day, the nation has been stereotyped by reports of religious, moral, and sexual events that misrepresent the underlying attitudes toward sexuality within this complex and diverse society. Unfortunately, this stereotyping has masked the country's sexual tolerance and openness prior to the enforcement of Victorian morality. This seeming contradiction toward the perception of sex can be explained through the context of history.

The term "sexuality" implies different things to different people across different eras. Depending on customs and lifestyles, it may refer to the act of sex and sexual practices, for others it may refer to sexual orientation or identity and/or preference, and yet for others it might refer to aspects of desire and eroticism; hence, the conceptualization of sexuality revolves around each individual's understanding and experience of it.

Ancient Indian history, for example, depicts a sexuality that varies substantially from that of modern India. The historic literature of India notes that in order to protect dynastic succession, polyandry and polygamy were common among rulers who had sybaritic lifestyles, yet commoners followed monogamous relationships. Furthermore, in ancient times, poetic and descriptive portrayals of nudity and eroticism occurred in a variety of forms. The oldest-known sex literature, "Kamasutra"

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by Vatsyayana, described the art of lovemaking as a science. Erotic paintings from the second century BCE at the Ajanta Caves in Maharashtra as well as the Hindu temple sexual sculptures at Khajuraho in Madhya Pradesh showcase esthetic presentations of lovemaking. Such openness represented the norm for centuries, but came to an end when the Western countries of Britain, France, and Portugal besieged the Moghul lands of Asia. After the Sepoy Mutiny—the violent uprising against British rule in 1858—the English stigmatized Indian sexual liberalism, and the strict Victorian rule of morality ridiculed the pluralism. Despite several developments against the Victorian rules, the attitude of sexual tolerance did not re-emerge, and now, even after Indian independence, the aura around the term "sexuality" is gray and carries with it elements of both stigma and concealment. Today, India is a nation of sexual paradoxes: For example, it is one of the most populated countries, yet it is a capital of male impotence; it is the land that gave the world the science and art of lovemaking through the Kamasutra, yet now it struggles with sexual violence against women and hate crimes against individuals having same-sex orientation. And perhaps most obvious from its burgeoning population, the culturally sanctioned understanding of sexuality is, "sex is a medium of procreation rather than recreation." This chapter aims to demystify the notions, debunk the myths, and narrate the real experiences of people as related to their sexual health in India.

3.2 Indian Sexual Health Scenario

Unfortunately, there is dearth of validated and quantitative data about the sex lives of Indians. In one of the more comprehensive and well-implemented studies of sexuality in India, the National Family Health Survey (NFHS) carried out its fourth iteration of a large-scale, multi-round analysis based on a representative sample of households throughout India. Among other topics, this survey provides state and national information for India on fertility, the practice of family planning, maternal and child health, reproductive health, and family planning services. The 2015–2016 sample of more than 100,000 men and women (ages 25–49 years) provided data related to various sexual characteristics and behaviors of Indian men and women.

Among the NHFS survey data relevant to this chapter, the median age of first sexual intercourse of Indian men was 24.3 years, for women 19 years. Ten years ago, the age at first sexual intercourse was younger for both sexes, 22.6 years for men and 17.6 years for women [1] (Fig. 3.1). These data were compared to those of ten other countries collected through global family health surveys [2], revealing that Indian men had their first sexual experience (at 24 years) later than men in all other countries, compared, for example, to men of Columbia at 16.2 years. Currently at 19 years, Indian women fell in the middle of their range, compared, for example, to women of the Congo Republic (16.8 years) and of Myanmar (22.5 years). A number of social, personal, psychological, and emotional factors can explain differences and changing trends in the sexual habits of Indians.

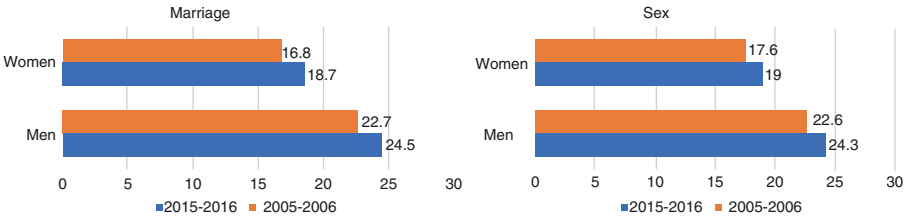

Fig. 3.1 NFHS survey depicting age of marriage and first sexual experience in the years 2005–2006 and 2015–2016

3.2.1 Education Delays Sex

The gender difference regarding the age of first sexual encounter is related to the age of marriage. Marriage, which is nearly universal in India, precedes the first sexual experience, as premarital sex is generally considered taboo. As a result, women overall have sex at an earlier age because they marry at a younger age. However, these ages are further qualified by educational attainment, such that the higher the level and duration of education, the greater the delay in the age of marriage and, hence, first intercourse. Such findings suggest that more recent generations are, overall, placing greater emphasis on socioeconomic goals relative to their personal desires related to marriage and sexuality.

3.2.2 Youth and Premarital Sex

Premarital sex is considered taboo and thus occurs infrequently. Later school years are marked by a significant transition toward adulthood, as characterized by personal decisions and choices, defiance toward family and school authorities, increasing curiosity to explore, and opportunity to mix with a wider array of individuals, including those from the opposite sex.

Although understanding sexual development during this particular phase of life is important, as such experiences during this time lay the foundation for adult sexual behaviors and roles, studies focusing on the sexual experiences of college students in India are relatively scarce, and observations derived from these studies are varied. Little is known, for example, about the role that family-, peer-, college-, and individual-level factors play in determining whether or not youth engage in premarital sex, and more importantly, the extent to which such sexual experiences are actually desired. NFHS data suggest that only 11% of unmarried men and 3% of unmarried women indulge in premarital sex, percentages that are fairly low in comparison with other cultures. Among unmarried women and men who report premarital sex, activity varies by location/region within India, occupational status, level of education, and level of household wealth.

In another study, Minakshi Tikoo [3] assessed the sexual attitudes and behaviors of 890 students (397 girls and 493 boys) aged 10–17 years in a public school in New Delhi, India. Students in grades 6–12 showed significant age and gender differences in response to statements measuring attitudes and behaviors (e.g., older adolescents and boys generally were more knowledgeable about sex), but both boys and girls strongly agreed with the statement that "sex is ok only if one is married." Consistent with this attitude, reported sexual activity and experimentation were generally absent. This lack of activity is coupled with a lack of knowledge: the All India Educational and Vocation Guidance Institute found that between 42% and 52% of young students in India feel that they do not have adequate knowledge about sex [4]; and a recent survey conducted by *India Today*, a leading news magazine, in 11 Indian cities revealed that almost half of all young people interviewed did not know enough to protect themselves from HIV/AIDS. Despite inadequate data, underreporting of sexual experiences should be considered common, as such behaviors are considered culturally inappropriate. In-depth interviews with medical practitioners, cultural leaders, and parents have, for example, revealed underreporting of premarital sexual practices among youth and adolescents.

During counseling sessions with the author, instances of underreporting of premarital sexual practices were evident in both men and women. An attractive young software employee confided, "My ex-lover ditched me after I got physical with him, saying (about me) that I might have fidelity issues in the future." One fellow, an aspiring cinematographer, stated, "I have a live-in partner. But I don't think she will marry me owing to my financial standards. When my parents arrange my marriage, I would not discuss my past to my wife." Respondents belonging to either the higher class or a lower education level tend to be more permissive about premarital sex, whereas religious-minded respondents tend to be more traditional in their views. The arranged marriage system still dominates within Indian culture, and with it, the value placed on chastity at the time of marriage. According to societal and familial norms, premarital sex is not permitted, and families go to great lengths to protect the chastity of unmarried youth, especially girls.

Any type of premarital sexual experience molds future relationships by setting expectations. Thus, traumatic relationships involving rape or molestation can often affect future relationships in multiple ways, especially when such negative relationships are combined with sexual feelings involving pleasure, because these victims may seek fulfillment in ways that are psychologically and physically unhealthy for them. Today in India, within the health profession community, the prevailing mentality toward sexual exploration is non-judgmental, yet emphasizes the importance that young adults understand its implications and make healthy choices that minimize risks of sexual coercion, unwanted pregnancy, abortion and its consequences, and sexually transmitted diseases (STDs) [4, 5].

3.2.3 Gender Perceptions of Sexuality

In India, sex is an "under cover" activity, performed in the dark and seldom discussed openly. Even in school, teaching about the reproductive system elicits

cringing, joking, and nervous giggles. So it is not surprising that, based on the NFHS survey, on average only 50% of Indian women and men have reportedly had sex during the previous 4 weeks. India has had a long history of strong, clearly defined gender roles. As with some other parts of the world, men are expected to repeatedly "prove" their masculinity. In India's male-dominated tradition, reinforced by pervasive themes throughout Vedic (ancient religious texts, ca 1000 BCE), classical, medieval, and modern Hinduism, the paradigms in myths, rituals, doctrines, and symbols are masculine.

In the past, women were looked upon with grace and consideration. However, in post-Vedic times, women's importance in both the home and society declined. In the period before Indian independence, this decline was manifested in many ways, such as secluding women by their wearing the purdah (an all-encompassing garb that obscures them from the gaze of men or strangers), the sati tradition of women throwing themselves on the funeral pyre of their husband, dowry demands, and childhood marriages. Except for sati deaths, the post-independence era continues to stigmatize and seclude women, although usually with more subtlety.

The sexual scripts of men and women in India are strongly inculcated and followed. Although husband and wife both contribute to the maintenance of the family, the social constructs surrounding sexuality are clearly defined. Sex was "given" to women for the purposes of species perpetuation through reproduction, and her role includes upholding the socio-cultural heritage through the generations. For men, who are the "givers," the prime motives for sex are the experience of sexual pleasure and the pride in perpetuating the family progeny. Such sexual scripts generally weigh more heavily upon women than men, although given the strong culture of masculinity, many men feel they must channel their need for love, intimacy, soothing, caring, and comfort into sexual desire and prowess. Female sexuality or behavior, on the other hand, is generally dismissed as being little more than animal sexual behavior, something to be controlled physically, psychologically, and emotionally by restricting the expression of interest in, desire for, or need for sex. Traditional and cultural practices, such as enforced modesty and chastity, are directed mainly toward women [6].

3.2.4 Synthesis

The strong cultural traditions currently dominating in India regarding premarital sex, gender roles, and sexual scripts—while not that different from other developing nations—represent a traditional patriarchal view that places value on female chastity and the control of women's sexual lives, and limits women's role outside the home/family. Men, too, are sometimes (though typically less so) the victims of a system that adheres to rigidly defined sexual and relational scripts that require recurring proof of masculinity and sexual dominance. The combination of class differences, social media influence, and changing attitudes of women is likely to effect rapid changes in traditional sexual scripts for men and women in India—with both positive and negative consequences. For example, greater openness about sexuality may allow women (and sexual minorities—see later sections) to increasingly

explore their sexuality while concomitantly resulting in backlash as more traditional sectors of society perceive such changes as threatening to the stability of the status quo—which has its own beneficiaries.

3.3 Sexual Dysfunction in Men and Women in India

3.3.1 Male Sexual Dysfunction

One of the earliest studies on male sexual dysfunction in India, reported in 1959 [7], not only acknowledged the existence of male sexual disorders, but also recommended the need to address them through the use of education-based group therapy. Ignorance, superstitions, fears/anxieties, and guilt feelings about sexual practices and problems were identified as major areas of concern, and were managed through education focusing on anatomical, physiological, and psychological issues related to sexual disorders. The phenomenon referred to as "dhat syndrome" was identified, publicized, and described clinically by symptoms consisting of fatigue, loss of libido, impotence, and guilt, associated with the loss of semen (e.g., in urine or due to masturbation). Dhat continues to be a common sexual issue among men in India, with key management strategies involving patient listening, constant reassurance, and gentle challenging of false assumptions surrounding the reality of semen loss [8].

Other sexual dysfunctions in men in India appear to occur with some regularity. Although data specific to India are scant, one recent epidemiological exploration concluded that one in five (21%) men suffered from one or more sexual disorders: specifically, among those men who were diagnosed as having a sexual disorder, about ¼ suffered from more than one [9]. The prevalence of erectile dysfunction was estimated at 16%, low sexual desire at 3%, and premature ejaculation at 9%. Other studies, however, report considerably higher rates of dysfunction. For example, Thangadurai et al. [10] concluded 43% of men had premature ejaculation and 48% had erectile dysfunction, attributing these higher rates to underreporting due to inhibitions and sensitivity surrounding the topic. The most common perceived causes of sexual dysfunction by participants were loss of semen due to masturbation and nocturnal emission (related to dhat syndrome). Given the fairly high prevalence of sexual problems, the misattribution to semen loss, and men's self-treatment that often resorted to herbal remedies and traditional healers, one study [9] recommended the urgent need for better training of health professionals on sexuality-related issues through curricular innovations. In addition, the study urged widespread sex education for the general population using media, and merging sexual health care with primary care.

Men suffering from chronic alcohol use are particularly prone to sexual problems, although prevalence estimates vary widely, ranging from 8% to 95% in India [11–19]. Frequent alcohol use affected all phases of the sexual response, including sexual desire [13–15], premature ejaculation [16, 18], and erectile response [17, 19,

20]. One recent article [21] identified erectile dysfunction as being the most common problem, followed by a lack of satisfying orgasm and premature ejaculation.

Erectile Dysfunction in India India is the second most populous country in the world, with a sex ratio leaning toward men.[1] Compared with China (which has the largest overall population), India has the greater number of men in the reproductive age group. The hassles of modern life and urbanization have exacted a large toll on men's health in India. Long workdays and commutes, poor dietary habits, heavy smoking and alcohol consumption, and a lack of physical fitness tend to suppress sexual desire in men. Lifestyle diseases, including obesity, diabetes, coronary artery disease, and systemic hypertension show, in turn, elevated prevalence in these men. Given that erectile dysfunction shares similar pathogenesis as the above diseases, India is on track to becoming the "impotence capital of the world."

Indians, especially men, place a high premium on women's virginity, enforcing this moral burden to the extent that virginity is preserved as an asset until marriage. However, consequences follow from the combination of coerced virginity and arranged marriages. Some marriages may not be consummated until years after the wedding, most probably the result of personal dislike or disdain toward the partner, low perceived physical attractiveness of the partner, or simply not knowing the mechanics of intercourse. As of late, the author has been counseling several couples each month who have difficulties consummating their marriages. Culturally, men are reared in an environment that entitles them to sexual pleasure and which is then "dispensed" to women at their discretion. Yet, women in India nowadays are more knowledgeable, more socially and financially independent than ever before, and more likely to understand what they want when it comes to sex. Yet sexual exploration can become a liability for women—being undesirable in the eyes of some men, intimidating them, or just putting them off—thus decreasing their chances of marriage. Specifically, sexual knowledge and willingness to explore prior to marriage may be encouraged in women, but men that are comfortable with women's choices before marriage do not appreciate the same from their wives.

Factors associated with male sexual dysfunctions range from anatomical causes, lifestyle diseases, and hormonal issues, to psychological issues such as depression, anxiety, and stress (e.g., from financial burden). In the Indian health care system, such concerns are neither discussed by patients nor probed by healthcare professionals. Patients often believe these problems are permanent or untreatable; hence, "suffering has to be endured." Lack of knowledge about the issues and lack of sensitivity to such patient concerns exist within the medical community. Furthermore, many patients have no idea where to turn within the medical system when they experience problems (e.g., which specialist to go to), and often they ultimately turn to quacks, crooks, or traditional healers who offer no proper resolution.

[1] India has about 110 males for every 100 females. Although this may not sound so skewed, in actual population numbers it means there are about 40 million more males than females.

3.3.2 Female Sexual Dysfunction

In India, people—and especially women—are reluctant to speak about sexual problems, a centuries-long cultural taboo that persists today. Generally, the populace lacks knowledge about sex and sexuality, to the extent that some do not even know the names for their genital organs. As mentioned earlier, many Indian women consider intercourse as merely a way to reproduce, with factors such as her education level, socioeconomic status, psychological and emotional health, social taboos, and general well-being playing a role in her attitudes about sexuality. Even though Indian women view reproduction as the primary function of sex, they are no exception in experiencing sexual dysfunctions. Several studies cite a high prevalence of sexual dysfunction in women; in the oft-cited National Health and Social Life Survey of 1992 [22] which evaluated 1749 women aged 18–59 years, 43% of women reported sexual dysfunction. Female sexual dysfunction (FSD) was found to be age-related, progressive, and highly prevalent, affecting anywhere between 30 and 50% of women depending on specific parameters.

As noted earlier, education/literacy and socioeconomic status play important roles in the evaluation of sexual health. For example, FSD in illiterate women was about 7%, but in women with middle education it was 49%. The same pattern was found with respect to socioeconomic status, where the prevalence of FSD was greater in women of upper middle status (36%) compared to lower socioeconomic status (15%) [23]. Such profound differences can be attributed to the fact that educated women are more able to share their thought processes and articulate the problems and issues about the condition, and probably more aware of available treatment options.

Research on FSD has identified many primary medical conditions that are associated with FSD, including hormonal, anatomical, vascular, and neural. The link between general medical issues and sexual problems has been demonstrated in Indian women as well. Women attending a medical clinic in Southern India [24] were found to have high levels of dysfunctions in all domains of sexual response: 77% in desire, 91% arousal, 97% lubrication, 87% orgasm, 81% satisfaction, and 64% pain. At the same time, sexual dysfunction related to a primary medical condition is often not recognized within clinical settings. Roy et al. [25], for example, have documented severe sexual dysfunction related to clinical depression in all domains of the female sexual response cycle: about 70% in depressed women compared to 20–40% in control women, depending on the specific assessment measure used: ASEX-F or the FSFI. Their study documented an early onset of sexual issues related to the occurrence of depression, suggesting the importance of treating the depression first in order to treat the sexual dysfunction. To the extent that depression is commonly associated with major health issues, it is not surprising that many stroke victims suffer from serious depression and further, that sexual dysfunction, including loss of libido, occurs after stroke. However, sexual dysfunction in women post-stroke also appears to be independent of the effects of depression [26], thus placing such women at multiple risk for sexual problems. Finally, other organic risk factors for sexual dysfunction in women include obesity, vulvovaginal surgeries,

hypothyroidism, and diabetes mellitus, some of which—along with peri- or post-menopausal status—are associated with vaginal atrophy owing to drastic hormonal/estrogen changes in women. Since many of these conditions are age-related, it is not surprising that with the increased duration of marriage, the frequency of intercourse decreases, leading to satisfaction disorder in many women in India [27].

Sexuality issues in the aging female population in India are not only ignored, they are sometimes the subject of ridicule. Research on men and women 50 or older in India indicates that among 50–60 year olds, as high as 72% were sexually active, and above 60, as high as 57% were active. Yet, the differences between men and women in this regard are striking. By the age 50, 57% of women were no longer sexually active, compared to only 17% of men [28]. Women with sexual problems were hesitant to seek help or, if they did muster the courage to do so, they often failed to disclose the actual reason for their clinic visit.

Within my own practice, many women—on average about one a day—above 60 years reveal sexual problems. A typical situation might be characterized by a female patient of 60+ years who recently disclosed, "Doctor, my privates are very dry and pains terribly every time I have sex. My husband does not seem to understand this and gets irritated and beats me up if he notices me frown with pain. I want to satisfy him. However, do not share what I told you with my daughter-in-law as she may lose respect for me." Such revelations illustrate the cultural bind that many women—not just the elderly—must negotiate when dealing with sexual issues. At times, discussion of the woman's "problem" may actually be initiated by the husband, for example, men who bring their wives in for sexual health counseling. Consider the 80-year-old man who visited my clinic with his wife and who, after undergoing a medical evaluation for comorbidities, actually owned up to the real issue of his not being able to have sex: "Madam, my wife doesn't cooperate with me for sex. I need it at least thrice a week. She says, sex is only for people <40. But I get turned on every time I see her. She says I am a sex maniac. I have been suffering all these years just trying to convince her every time before intercourse." At one level, such statements reveal the burden that women sometimes must face within a culture that sees women's sexuality as an obligation to the husband rather than a right of its own. At another level, it affirms that even in a sexually repressive culture toward women's sexuality, discussions about sexuality, and intimacy—even among the elderly where sex is considered abnormal or taboo—can be prompted, given an open and permissive atmosphere. Such an atmosphere can be facilitated by including an appropriate sexual health evaluation as part of general health visits to the hospital.

Approach to Female Sexual Dysfunction The course of sexual wellness in women in India is heavily influenced by the reproductive events of pregnancy, breastfeeding, and menopause. Triggers of acute physical and psychological illness related to these events, superimposed by social inhibitions, affect women's relationships with their partner. Although biological and reproductive physiological changes influence women's sexual function, psychological factors play a key role. For example, women with desire disorders often have anxiety issues, low self-esteem, emotional

instability, and neuroticism. Relationship issues and marital conflict as well as pre-existing psychiatric or psychological disorders, including body dysmorphic disorder (BDD), have negative impacts on both personal and sexual well-being. Furthermore, prior negative sexual experiences may influence current sexual functioning: memories of past negative sexual experiences, including coercive or abusive relationships, and expectations of negative outcome from dyspareunia or partner sexual dysfunction all adversely impact sexual function. Hence, the healthcare professional needs to identify, assess, and manage such issues while dealing with FSD.

FSD is prevalent in fertile women as much as in infertile women, but it is often neglected in the former: while fertility issues in India often bring the woman to the clinic, issues about sexuality seldom do. Furthermore, FSD is inadequately studied in the Indian female population, especially in the illiterate and low socioeconomic classes. These women often end up being silent sufferers of FSD, as rarely do they present with sexual dysfunction unless other reasons bring them to the clinic, such as pelvic pain, menstrual irregularity, the need for contraception, or vaginal infection. Thus, in India, women who visit the clinic for reproductive issues need further probing for possible FSD issues. As most women in India are receptive/passive with regard to their sexual/gender role, they often need to be prodded to discuss their expectations within their sexual relationship, expectations that may be strongly influenced by ongoing interpersonal conflict and the overall quality of their relationship and intimacy [29]. Nevertheless, today's women in India are more knowledgeable, liberal, and open to sexual exploration than ever, so when appropriate it is important to address their issues to help them overcome inhibitions and experience a more satisfying sexual life.

3.4 Sample Treatment of Sexual Dysfunction in an Indian Context

Although many of the general guidelines developed by international organizations (e.g., International Society of Sexual Medicine, ISSM) for treating sexual problems apply to the situation in India, the Indian cultural context requires particular awareness of and sensitivity to a number of culturally engrained expectations. Here insight is offered about how to approach a sexual situation and extract information about sexual wellness from a patient who makes an office visit for a health ailment not related to a sexual problem. Although a number of standardized assessment instruments are available, the major challenge for the healthcare practitioner in India is that of establishing a context in which the patient feels comfortable about discussing a sexual issue. Hence, the algorithm that follows—self-explanatory for the most part—is specific to an Indian context where discussion of sexuality topics is considered taboo by patients and where the practitioner him/herself may lack in-depth knowledge and professional comfort in performing the evaluation (Fig. 3.2).

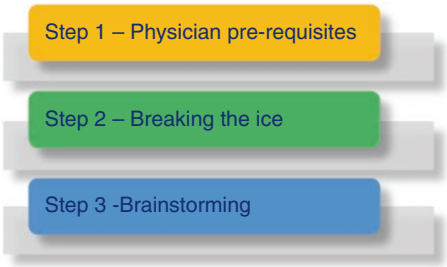

Fig. 3.2 Three important steps to managing patient sexual issues

Competence	Be competent in your specialty to ensure the best diagnosis & treatment
Confidentiality	Ensure confidentiality of the patient and the presentation. Patients are who comfortable to share that they are diabetic might not be comfortable to share that they have ED.
Compassion/ Comfort	Keep the environment comfortable. Avoid unnecessary calls. Mind the body language. Practice compassion.
Completeness	Evaluate the patient completely. Look for masked sexual health disorder/incidental findings
Continuity	It is not one visit that will give the solution. Follow up with the patient.

Fig. 3.3 Step 1: ensure 5 C's

Although this approach has not been validated empirically, the clinical experience of the author attests to its effectiveness.

The process might be broadly conceptualized in three steps:

- Step 1: Physician prerequisites (Fig. 3.3)

The evaluation of sexual health in the Indian setup is quite challenging unless the patient him/herself visits the clinic for the express purpose of a sexual problem (which is rare). Labeled as the five C's, these prerequisites are appropriate within any specialty, and awareness of these is prudent when a probable sexual health concern is suspected.

- Step 2: Breaking the ice (Fig. 3.4)

The first interactive step with the patient is encouraging him/her to speak up about an issue when a sexual problem is suspected. Most of the time, the sexual problem is masked by another presenting complaint or identified as an incidental finding during evaluation, for example, a complaint by a woman about vaginal

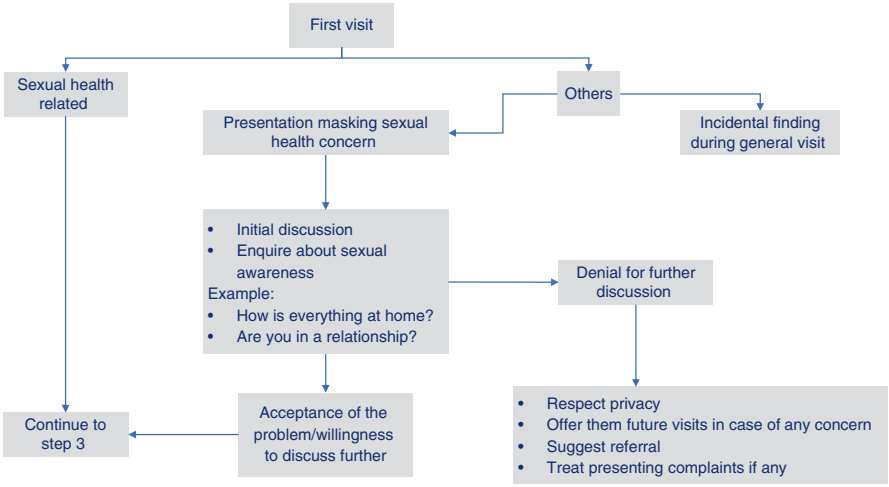

Fig. 3.4 Step 2: breaking the ice

dryness/leucorrhea masking vaginismus/dyspareunia. Even upon identifying a probable sexual health issue, the patient may refuse to discuss or deny the presence of an issue. As mentioned previously, the evaluating physician must gain the confidence of the patient by approaching the issue slowly (with long lead-in questions that encourage the patient to gradually open up), thereby eventually extracting a solid history of the situation before a diagnosis can be reached. However, if the patient still refuses to acknowledge a problem, ethically, the physician may suggest a referral or offer an opportunity for discussion at a future visit.

- Step 3: Brainstorming (Fig. 3.5)

This step involves taking a detailed history of the problem. The general components of history taking are identical to those of any other specialty; however, several specific questions under each sub-heading (common cues of sexual dysfunction: Fig. 3.6) would narrow the diagnosis, including the phase of sexual response cycle where the problem lies and whether the problem is likely to be primarily organic or functional/psychological, or both. Although more in-depth knowledge of sexuality may be required for differentiating phases and etiologies, several examples can be used to assist in this process. Accurate clinical assessment and individualized management of sexual symptoms depends on the diagnosis.

Management of sexual disorders in women necessitates special mention because of several fundamental differences within this population. For example, in India, many women complain of an extended period of sexual desire or arousal disorders after childbirth and after menopause. Although hormonal changes play an important role, the very thought of indulging in sexual activity in these periods seems quite

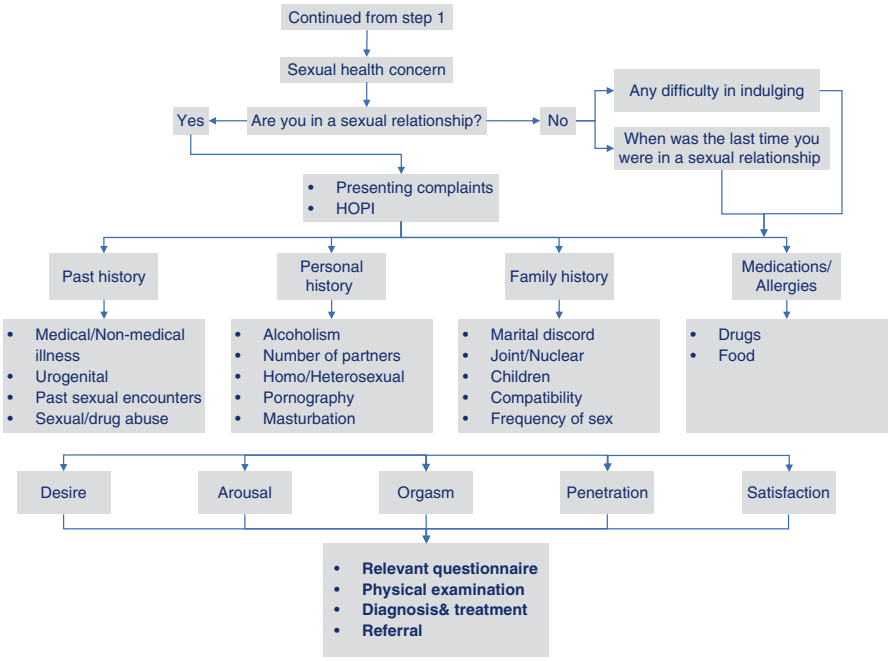

Fig. 3.5 Step 3: brainstorming

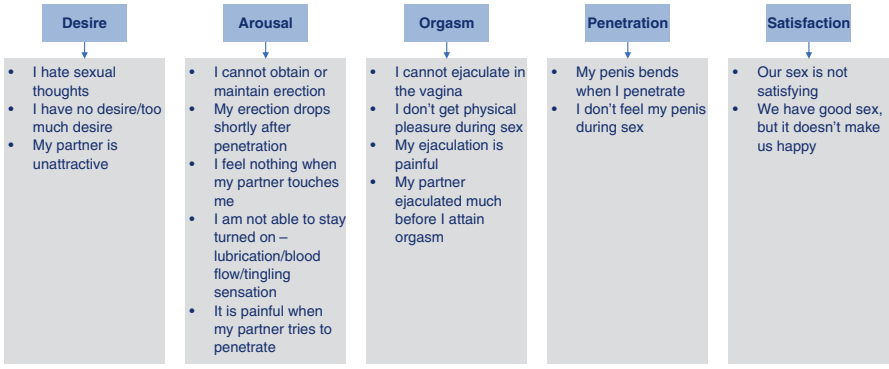

Fig. 3.6 Common cues of sexual dysfunction

unnatural for many women. Hence, women should be given constant reassurance regarding their sexual health concerns when they visit the clinic during these phases of their lives so they understand that while such feelings are normal, treatment options to address them are available.

3.4.1 Synthesis

Not surprisingly, the sexual dysfunctions noted within the Indian population mirror those of the rest of the world. However, the Indian context suggests a number of issues that require special attention. For example, the overwhelming concern regarding dhat syndrome by men and the lack of knowledge within both sexes regarding normal and dysfunctional sexual response suggest that public knowledge regarding sexuality among much of the population is not just inadequate, it is largely nonexistent. Given challenges regarding patient communication about sexual issues, along with general lack of knowledge regarding the role of lifestyle factors, comorbidities, and aging/health on sexual response, it is not surprising that studies on Indian populations tend to find high levels of sexual dysfunction. Among the greater challenges for healthcare professionals in India are those of being able to recognize an issue when it is presented, helping patients recognize sexual problems and sexual potential, providing an open environment that removes the stigma/taboo surrounding the discussion of sexual issues, and providing access to services that assist not only with reproductive functions but also with issues about sexuality.

3.5 Issues Surrounding Women and Sexual Minorities in India

3.5.1 LGBTQ Status and Issues in India

Sexual identity, orientation, and behavior within the LGBTQ community are complex in any social system and often in need of clarification. One's identity refers to how an individual self-identifies, regardless of their orientation or sexual behavior. For example, men who have sex with men (MSM) status does not reveal a sexual identity or explain the behavior, but merely describes the sexual practices of such men. In India, a heterosexual male, otherwise married, may have a male partner to share his sexual intimacy, but this does not necessarily mean he will seek physical relationships with other men, nor necessarily that he will identify himself as MSM.

Given the diversity within the LBGTQ community, linguistic and cultural designations have often represented them either too simply or even incorrectly. In contrast with traditional (though not more recent, see Chaps. 4 and 7) Western culture, these sexually diverse individuals in India often do not fall within distinctive categories (e.g., homosexual, heterosexual, bisexual), but identify using the more colloquial terms of "kothi" (effeminate male partner) or "double-deckers" (men agreeing to both receptive and penetrative sex). Nevertheless, such terminology may not reveal their sexual identity: For example, in India there is a distinct group called hijras or transgenders who are biological males, with or without having undergone ritual castration. Although numerous studies have documented same-sex behavior in India, prevalence rates from these studies are likely questionable, given the stigma attached to such behavior and therefore the reluctance to report it.

Being LGBTQ in India Many MSM in India, irrespective of their sexual identity and object choices, are married [30], with studies from various parts of India indicating anywhere between 11 and 60% [31–37]. Pertinent to lesbians in India, marriage is probably the most difficult situation they are forced to endure—second only to issues of accepting their identity. Although the institution of marriage affects women in many ways in India, the lesbian case warrants special consideration, as the fear of being "caught" severely impacts the quality of their lives.

Within India's LGBTQ community, the hijras (or transgenders) have formed a secretive subgroup. In the first ever census data on this group, the transgender population was estimated at 490,000. Due to lack of access to education within this group, the employable population was under 45%, and as result, many hijras engage in prostitution for their livelihood. Despite Indian society's climate of acceptance and tolerance toward some aspects of sexual diversity, knowledge and understanding of gender identity issues and same-sex orientation seem to be limited. People whose gender identity and expression are incongruent with their biological sex are often disparaged in many ways, and most families do not accept if their male child behaves in ways that are considered feminine or inappropriate to the expected gender role. Some parents may actually evict or disown their child for gender-incongruent expressions and behaviors. Within some circles, lesbian women are brutally forced into family-sanctioned corrective rapes, often orchestrated by brothers or the father. Parents rationalize their actions by identifying the child as a disgrace or shame to the family. They view their child as unmarriageable, unable to care for a family, and unable to produce a family heir. Unable to tolerate such ostracizing and discrimination and/or not wanting to shame the family, such youth or teenagers often flee the home.

Discrimination in Healthcare Settings LGBTQ individuals face discrimination even within healthcare settings. They are not offered the level and kinds of treatment as other patients, and they are generally made to feel unwelcome. India has the third largest HIV problem in the world, with 2.1 million people living with HIV/AIDS [38]. India's epidemic is concentrated among key subgroups, including sex workers and men who have sex with men (MSM). However, these subgroups face unique barriers when attempting to access public or private health services, with their reduced access to HIV testing, antiretroviral treatment, and other sexual health services having been well-documented. According to a recent paper in *The Lancet*, 2/3 of transgender people in India and Pakistan had no access to treatment for sexually transmitted infections (STIs) [39]. Only 59% had been referred for HIV testing and 67% had not been given proper counseling about antiretroviral therapy.

LGBTQ Rights in India Figure 3.7 depicts the present state of LGBTQ acceptance in India. Every year in February, thousands of LGBTQ individuals take to the streets as part of LGBT pride. Irrespective of several positive movements supporting the

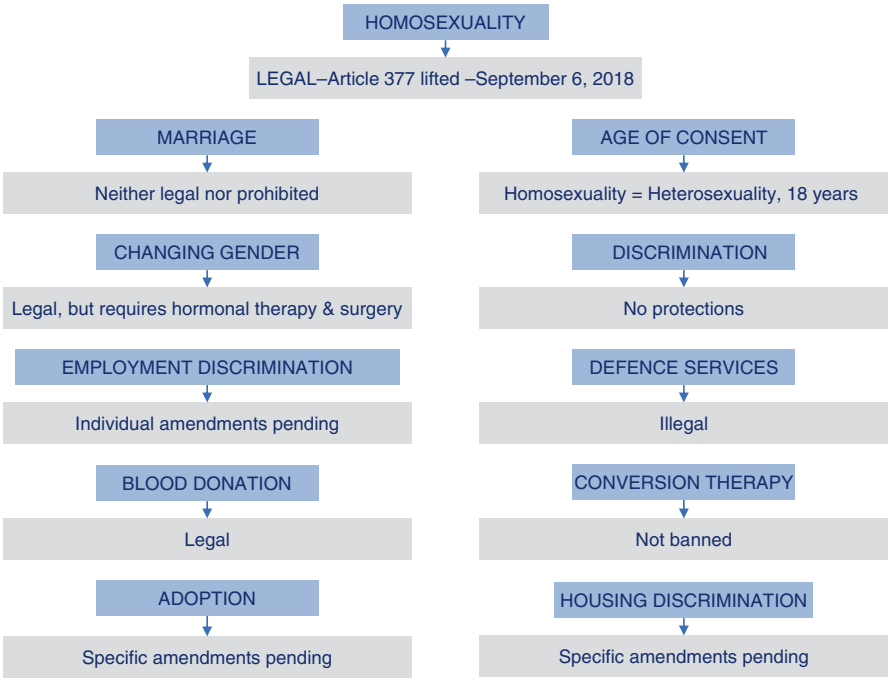

Fig. 3.7 LGBT rights in India

uplifting and equality of these groups, Indian society continues to be dominated by outdated cultural norms that dictate the terms and conditions of education, career, and marriage. For members of the LGBTQ community, such cultural norms are manifested in multiple ways. The lack of family support negatively affects the mental and physical health of LGBT people. Social isolation and body shaming often lead to depression, suicidal thoughts, and psychosomatic diseases. And a lack of health services results in increased morbidities due to STIs, including HIV. Thus, for members of the Indian LGBTQ community, tolerance—much less acceptance—remains an unthinkable dream. India is at a crossroads regarding this community: the country may move toward support and equality, or it may continue denial of basic human rights to these groups.

3.5.2 Sexual Violence in India

Talk about sexual violence has indeed become the need of the hour not just in India, but worldwide. Gender violence is the appropriate term for a varied range of violations that may be physical, sexual, or both. Though rape is reported by both genders, women represent the vast majority of victims in India, with rape being the most common form of violence against women ever since social science began taking

note of such issues. Such sexual violence represents a profound violation and shaming of victims' bodily and social integrity, leaving an indelible scar on the victim.

The case of Nirbhaya (a pseudonym meaning "fearless")—the 23-year-old student who was brutally raped and thrown out of a moving bus in Delhi—made headlines across the world in 2012. Nationwide protests claimed justice for the victim by demanding the highest allowable punishment for the culprits, with global media branding India as the "rape capital of the world" [40]. Since then, advocates for women's rights have pressured the government into taking substantial contraventions as well as stringent actions against perpetrators. Nevertheless, the situation today has hardly improved: recent crime statistics and expert opinion show a rape occurs every 20 min, with India topping the list of the most dangerous countries for women in the world due to the high risk of sexual violence, slave/forced labor, human trafficking for domestic work, forced marriage, and sexual slavery [41, 42].

On the surface at least, resistance appears futile, as rape is increasingly used as an instrument to assert power and intimidate the powerless in India. Although Nirbhaya was a 23-year-old young adult, youth are also vulnerable. The tiny girl from Kathua in the Union Territory of Jammu and Kashmir and the minor girl from Unnao district of Uttar Pradesh are standing examples of minority victimization [43]. On another horrific day, it was revealed that *30 girls in a state run Bihar shelter* were allegedly sexually abused over many years [44]. The general notion in the Asian subcontinent—in a hierarchical, patriarchal, and increasingly polarized society—is that violence in any form is being used to divide people and harvest votes.

Indeed, rape is trending in India! So much so that India's Supreme Court, the highest center of the judiciary, pondered: "What is to be done? Girls and women are getting raped left, right and centre" [45], a highly irregular stance for a supreme court anywhere, and one that underlines the gravity (and seemingly out-of-control nature) of the situation. The situation is further exacerbated by the large sex ratio imbalance—largely due to illegal sex-selection abortions—that means the country is overpopulated with men. India has about 110 boys born for every 100 girls (2017–2019), compared with the natural sex ratio closer to 105 boys to 100 girls (World Health Organization). In other words, this preference means that some 50–60 million women are statistically "missing," with this skewed ratio playing a potential role in the increasing crimes against women.

Sorting the Root Cause As with many social systems, Indian society is becoming increasingly sexualized. Violent and demeaning pornography as well as explicit sexual content in films and music has become increasingly accessible to every person of India. Children are no exception. Curiosity is piqued in children who are deprived of basic knowledge of sexual issues as they approach adolescence. Sex education provides an important way of addressing the issue, yet parents and schools strongly resist any attempts at implementing such programs, ensuring to some extent that women will continue to struggle at the hands of sexual violence.

Putting Women in Positions of Influence The international #MeToo movement has brought more empowerment to women, who are increasingly disclosing their

experiences of sexual abuse and violence. Massive social outbursts in India in recent times have helped ensure stricter laws, and greater accountability and punishments. Currently, however, the Indian legislature has only 12% women in parliament, while they comprise 48% of the population. Although placing Indian women in positions of political power will not, by itself, resolve longstanding, pervasive, and entrenched cultural attitudes that tacitly allow violence against women, an Indian government having more women could enact comprehensive legislation that might protect women from abuse and provide programs that aid in recovery.

3.6 Recent Laws and Regulations Affecting Issues of Sexuality in India

A number of laws and rulings have occurred in India that have begun to address longstanding injustices. Such steps suggest an increasing awareness of the challenges facing India society and the need to take action.

3.6.1 Sex Education

In the majority of Indian households, sex education involves a one-time discussion explaining the process of puberty and how the sex act occurs. Other potential sources of information may be blocked; for instance, parents may change the television channel when contraceptive or feminine hygiene commercials are played, foregoing the opportunity to use the event as a means to introduce the topic of menstruation or contraception to their children. Parents, schools, and even state and regional governments deny the need for multiple and progressing levels of sex education. Yet this lack of compulsory and comprehensive sex education in schools violates the human rights of Indian adolescents and young people, as recognized under international federal law.

Aware of this gap, the Central Government of India developed the Adolescent Education Program (AEP) in association with National AIDS Control Organization (NACO) and UNICEF for implementation in all secondary and higher secondary schools. The objectives of the AEP were:

(a) To ensure the integration of AE elements into the school curriculum and in teacher education courses,
(b) To organize activities for life skills development,
(c) To help students acquire authentic knowledge about Adolescent Reproductive and Sexual Health (ARSH) including HIV/AIDS and substance abuse,
(d) To inculcate in students essential life skills to develop healthy attitudes and responsible behavior toward ARSH issues, including HIV/AIDS and substance abuse.

Strong objection arose to parts of the program in many regions of India, with objectors contending that explicit content was objectionable to Indian culture and

morality. As many as 12 state governments thus banned the program, including the highly populated states of Madhya Pradesh, Maharashtra, and Gujarat [4]. One claim put forth by objectors was that sex education increases risky behavior among adolescents and young people; yet research supported by the World Health Organization (WHO) [46] has shown that sex education *does not* encourage sex at an earlier age or more frequently, but rather delays the start of sexual activity, reduces sexual activity among young people, and encourages those already sexually active to have safer sex.

In a countermove to the resistance toward sex education in India, the Youth Coalition of Sexual and Reproductive Rights (YCSRR) has appealed to the United Nations, arguing that India is obliged to provide comprehensive sexuality education in all public and private schools and that the denial of such education to children, adolescents, and young people—and the banning of the AEP by state governments specifically—is a violation of India's commitments under international law. The group has further argued that banning such knowledge on the basis of culture, morality, or federalism is invalid within the context of this commitment.

Educating children and youth about their bodies and sexuality in an age-appropriate way could have many specific positive social effects. In addition to learning about healthy sexual behaviors, such education could help youth understand the difference between sexual and non-sexual touch, help them escape the guilt and fear that often accompanies sexual abuse, and empower them to disclose previous or ongoing abuse. Furthermore, the provision of age-appropriate comprehensive education on sexuality and STI/HIV/AIDS could have important consequences in reducing the spread of sexually transmitted infectious diseases.

3.6.2 Bidding Farewell to Article 377 of the Indian Constitution

In a major turn of events in 2018, the Supreme Court of India overturned a 157-year-old law criminalizing gay sex. It scrapped Section 377 of the Indian constitution, a colonial-era law banning gay sex, and in doing so, ended the legal basis for discrimination and marginalization of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community in the world's largest democracy [47]. In reading the final judgment, Justice Malhotra commented, "History owes an apology to the members of this community and their families, for the delay in providing redressal for the ignominy and ostracism that they have suffered through the centuries. The members of this community were compelled to live a life full of fear of reprisal and persecution. This was on account of the ignorance of the majority to recognize that homosexuality is a completely natural condition, part of a range of human sexuality…" Activists had struggled for more than a decade to invalidate Section 377 of the Indian penal code which prohibited consensual "carnal intercourse against the order of nature." In response to the ruling, several state governments, including Madhya Pradesh, Maharashtra, Tamil Nadu, and Punjab, have set up welfare boards to ensure equal opportunities in jobs and education for individuals having diverse sexual identities.

3.6.3 Sexual Violence

The 2013 Sexual Harassment of Women at Workplace Act (Prevention, Prohibition and Redressal) seeks to protect women in India from sexual harassment at their place of work. The act not only helps to ensure that women are protected in both public and private workplaces, but more broadly it will also contribute to the realization of women's right to equality, life, and liberty in working conditions everywhere. The new sense of security at the workplace will likely improve women's participation in the workforce, resulting not only in their own economic empowerment and inclusive growth, but also in that of the nation's [48].

3.6.4 The Protection of Children

The Protection of Children from Sexual Offences Act (POCSO Act) in 2012 [49] was enacted to protect children from sexual abuse, sexual harassment, and pornography, and to provide a child-friendly system for the trial of these offenses. According to the act, "child" was defined as any person below 18 years of age. All offenses under POCSO are considered grave, as indicated by recent amendments to include the death penalty for aggravated sexual assault on children and to ensure stringent punishments for other crimes against minors. Offenses booked under POSCO cannot lead to bail and are within the jurisdiction of the court system (as opposed to being justified on the basis of cultural traditions).

3.6.5 Synthesis

Although problems of abuse toward women, children, and sexually marginalized individuals in India have been culturally entrenched over the past several centuries, India is gradually—though perhaps not as rapidly as desired—moving toward social reformations that will help improve the human rights of women and sexual minorities. In this respect, India is moving toward a position more consonant with WHO and first world standards. The coming decades in India are likely to force India to re-evaluate its cultural traditions regarding sexuality. Such change, however, will not occur unchallenged and without resistance, and as is the case with social change in any longstanding cultural tradition, the process is likely to follow the clichéd "two steps forward, one step backward" pattern.

3.7 Conclusion

The sexual scenario is India is currently unsettled, with change both imminent and significant. India is on the cusp of social reforms that are likely to affect sexual scripts, sexual openness, and sexual help-seeking. Health professionals in India need to be prepared (and formally trained) for such developments. Relevant takeaways are summarized in Box 3.1.

Box 3.1 Recommendations/Take Away

- Conservative views of sexuality are currently the norm in the modern India. Sexuality is a point of contention between conservative and liberal forces and is being manifested in attire, behavior, recreation, literature, sculptures, scriptures, and religion.
- Although sexual problems are highly prevalent, these are frequently under-recognized and underdiagnosed in clinical practice owing to taboos that surround the topic. Management of sexual dysfunction in either gender involves a multimodal and holistic approach. In the Indian context, as a health practitioner, it is imperative to consciously adopt the patient's perspective and expectations. In the event of identifying a possible sexual disorder, appropriate referral should be made rather than shunning or avoiding the issue.
- Although sexual diversity may be increasingly acceptable to Indian youth, within the boundaries of family, home, and school, those experiencing discrimination constantly struggle for recognition and acceptance.
- The importance of sex education in India can never be understated. Comprehensive sexuality education not only empowers young minds but also ensures that they make informed, healthy sexual choices. Implementation of age-appropriate sexual education has the capacity to change the course of sexual violence, assist couples in dealing with unconsummated marriages, minimize sexually transmitted diseases, and afford greater recognition and equality to sexual minorities.
- Health care professionals are likely to have to deal with increasing sexual problems in clinical settings due to new awareness on the part of youth, women, and sexual minorities. In some instances, the burden will fall on men to find ways to adapt to such changes. Preparation and training of health professionals, with a newfound sensitivity regarding the issues that all groups are facing and experiencing, is key to developing an effective strategy for helping people deal with long-repressed issues surrounding sexuality, sexual identity, and sexual response.

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Lesbian, Gay, and Bisexuality from a Cross-Cultural Perspective

4

Kimberly Fuller

4.1 Introduction

The health needs of lesbian, gay, and bisexual (LGB) persons should be considered across all levels and ages of medical practice, from pediatric to geriatric care. Identifying as a sexual minority (LGB) is no longer believed to be a choice, preference, or lifestyle as once presented in popular culture [1]. Yet, despite consistency of the research literature, many adults in Western countries and elsewhere, including some within the medical community, still believe that one's sexuality is a choice, and continue to stigmatize such individuals and harbor negative bias against them [2, 3]. Even if a person predominantly presents as romantically and sexually attracted to one gender at one point in life and then changes interest to another gender at another time, this does not imply that the person is *choosing* an orientation. Especially for women, sexual fluidity may be a healthy expression of sexuality [4] and is common among those identifying as "plurisexual."

Recent research in Western cultures has found that LGB youth often begin questioning their sexual identity around middle school, between approximately 10 and 13 years of age [5]. By ages 15–18, most youth are usually certain about their identity as gay, lesbian, or bisexual, although they may delay "coming out" until around 18–20 [5], often when they are out of their parents' household. Although more youth than ever are out now, LGB elders often delay coming out, and some may not come out at all. Such differences among sexual minorities in Western culture indicate the importance of taking a lifespan approach regarding sexual health and medical care. Less is known about sexual identity development in non-Western cultures, where greater emphasis is placed on how one's identity alters traditional cultural roles of marriage and filial piety [6–9].

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Unfortunately, content specific to LGB needs is frequently omitted from health and sexual health information presented to medical students in nearly all cultures. This chapter provides key knowledge about LGB health so as to guide providers in the best practices for treating these patients' needs. This chapter first defines the meaning of lesbian, gay, and bisexual (LGB), then addresses critical issues regarding LGB sexual health, and lastly reviews the assessment, diagnosis, and treatment of problems within these groups.

4.2 Understanding and Defining Sexual Orientation

As sexual diversification has become more accepted and normalized throughout various parts of the world, the terminology describing sexual variation has greatly expanded. The language used 10–15 years ago no longer captures the complex possibilities that are described in today's literature. A critically important step, then, is understanding the language surrounding the sexual minority culture.

Historically, sexual orientation was defined by the "sex" a person was attracted to, where sex embodied the person's biological and chromosomal (XX/XY) characteristics. With the evolving distinction between "sex" and "gender," sexual orientation is now defined by "gender" attraction, that is, the social and cultural identity of the person to whom the attraction is directed. While a person may be assigned one sex at birth (e.g., male), that person may begin to identify with a different gender at some point during the lifetime (e.g., female or transgender). While biological sex is unchangeable, gender may be fluid and evolving, and for this reason, the term "gender" is used in defining and discussing sexual orientation throughout this chapter.

LGB is a commonly used acronym to describe people who identify as a "sexual minority," an umbrella term for those who identify with any sexual identity except heterosexual/straight [9]. The root hetero-, meaning "other," refers to a person who is sexually attracted to the opposite/or other gender. "Sexual minorities" is the terminology most commonly used in scholarly research, as it includes a wider range of sexual identities and does not limit discussion to just lesbian, gay, and bisexual identities (see Box 4.1 for a summary of important terminologies).

All sexual identities, including sexual minorities and heterosexual/straight persons, fall into either the "allosexual" or "asexual" category. Allosexuality defines a person having some sort of sexual desire, which may be specific to one gender (monosexual) or include a person of any gender (plurisexual). Asexuality is defined by the absence of sexual desire toward any person, regardless of gender.

Allosexual Within the category of allosexual, monosexuality refers to sexual attraction directed toward one other gender—either man or woman. The most common monosexual identities are lesbian and gay. A lesbian person is defined as a woman who has sexual feelings toward other women. A gay person is typically a man who has sexual feelings toward other men. However, some people use the term "gay" to indicate that they identify as *non-heterosexual*, and so this term may be

Box 4.1 Key Definitions

Sexual orientation: An inherent or immutable enduring emotional, romantic, or sexual attraction to other people.

Lesbian: A woman who is emotionally, romantically, or sexually attracted to other women.

Gay: A person who is emotionally, romantically, or sexually attracted to members of the same gender.

Bisexual: A person emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity though not necessarily simultaneously, in the same way or to the same degree.

Queer: A term people often use to express fluid identities and orientations. Often used interchangeably with "LGBTQ."

Asexual: The lack of a sexual attraction or desire for other people.

Sex: The sex (male or female) given to a child at birth, most often based on external anatomy. This is also referred to as "assigned sex at birth."

Gender identity: One's innermost concept of self as male, female, a blend of both, or neither—how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.

used by both men and women. Another common term used throughout history, "homosexual," which has the root homo- (meaning same) and means attraction to the same sex, is now considered an outdated term to describe someone who has same-gender attraction. Unless an individual specifically labels themself[1] with this term, it should be used with caution.

Conversely, plurisexuality refers to sexual attraction toward multiple genders. The most common of these terms is "bisexual," referring to a person who may be sexually attracted to any gender and may desire to engage in sexual experiences with men, women, and transgender/non-binary people. Some definitions of bisexuality include attraction and sexual desire for transgender or gender non-conforming persons, while others only define it as attraction to cisgender people (i.e., people who identify with their birth sex). Some people consider the terms "pansexual" and "queer" more inclusive. Pansexuality is often described as an identity more inclusive of transgender/gender non-conforming identities. The identity of queer has been reclaimed by younger generations, and is believed to encompass a broader landscape of identities. Older LGB persons may choose not to use or accept the use of queer, and may even find it a homophobic term based on the LGB cultural history of oppression as well as the original intent to use the word queer to "other" this

[1] This gender-neutral terminology (they, them, their, etc.), although at odds with traditional grammatical convention, is preferred in the LBG literature to gender specific terms such as he, she, him, her, himself, herself, etc.

group. Some people strongly prefer one plurisexual label over another, while others use them interchangeably.

4.3 Understanding Sexual Identity

The understanding of sexual minority identity development was originally outlined in Alfred Kinsey's 1948 book, *Sexual Behavior in the Human Male* [10]. Sexual orientation was depicted on a six-point scale, ranging from exclusively heterosexual (0) to exclusively homosexual (6), with, for example, a person identifying as a "3" being equally interested in the same gender as in the "opposite" gender. This scale, known as the Kinsey Scale, however, did not capture the true complexity of sexual orientation, and implied that attraction was the pivotal aspect of identity development.

While other scales have emerged over time, one of the most comprehensive scales, the Orientation, Behavior, and Identity (OBI) Scale created by Satterly and Dyson [11], expands the Kinsey Scale to three six-point scales—exclusively "opposite" gender at "0" and same gender at "6," with bisexuality ranging in the middle—to include sexual orientation, sexual behavior, and sexual identity. The OBI defines *sexual orientation* by whom the person is attracted to or interested in. Those whose sexual orientation falls between 0 and 6 might view themselves as attracted to both men and women, but might also be attracted more to one gender than another, essentially similar to Kinsey's scale. *Sexual behavior* includes all sex-related behaviors that people might engage in, regardless of whether or not they have yet acted on behavioral desires. For example, a person who identifies between 1 and 5 on the sexual behavior scale may have kissed both men and women in the past, find enjoyment only from kissing men but not from performing any other sexual acts with men, and might enjoy giving and receiving oral sex with women in the future. The third scale, *sexual identity*, refers to how the person would actually identify themself, and/or the label used (e.g., gay, straight, queer, pansexual, etc.). Some people may choose not to label themselves at all. Individuals may be positioned at different points along each scale, and as noted previously, this positioning may change over the life cycle.

Healthcare providers who routinely serve populations of sexual minorities may find benefit in using such tools as the OBI to assess the person's identity across each dimension so as to understand patients' unique healthcare needs. Alternatively, when healthcare providers are working with known persons of sexual minorities, they may consider using the OBI to help facilitate a conversation about appropriate needs and services.

Asexuality A gap in the current models of sexuality is the lack of inclusion of information about asexuality. Asexual persons, defined by their absence of sexual desire toward any person regardless of gender, may have no sexual desire, or they may engage in sex but not enjoy it or derive pleasure from it. Some individuals may identify as *gray-A* where their identity falls between sexuality and asexuality, or

"demisexual," one who may not desire sex with someone unless they have a strong emotional connection often seen—although not exclusively—in a committed relationship.

Little is known about asexuality, how it develops, and if it is a static or evolving identity. A recent controversial study suggests sexual trauma in the prior 12 months is associated with an asexual identity [12], and that asexuality may be linked to a sexual aversion disorder. Further research is needed to determine whether sexual trauma is a true risk factor for asexuality, and thus at this point in time this link should be viewed with caution. That is, providers should not assume that patients who identify as asexual have necessarily experienced sexual trauma, nor that the trauma contributed to their identity development. An asexual identity does not imply an underlying diagnosis nor necessitate treatment unless it explicitly causes distress. People who identify as asexual are often still involved in relationships, but place value on other aspects of the relationship and may still have a deep emotional connection to their partner. When treating all patients, but especially asexual patients, romantic identities should be taken into consideration.

Romantic Identity—A Deeper View *Romanticism* or *romantic identity* describes a person's emotional and romantic attraction to other people. The language of romantic identities—typically a Western characterization that may not have relevance within many non-Western cultures—parallels the descriptions of sexual identities: hetero-romantic, homo-romantic, bi-romantic, pan-romantic, and a-romantic. Most people's sexual identity and romantic identities align. For example, a person who is heterosexual may identify as hetero-romantic, feeling both sexually and emotionally attracted to people of the opposite/other gender. However, some people may show disparity between their sexual and romantic identities. Such persons may be more or less inclined in one direction sexually (e.g., gay), but may find themselves more romantically inclined in another direction (e.g., hetero-romantic), choosing their partners based upon their sexual or romantic attraction. Healthcare providers working with sexual minorities may find it helpful to include questions about emotional and romantic attraction in their initial assessments.

4.4 Key Considerations for Understanding LGB Healthcare Needs

Although unpacking and defining LGB identities provides cultural insight into working with the LGB population, there are several other key considerations for working with this population.

Heteronormative View of Sexual Minorities Sexual medicine is often presented through a heteronormative lens, one where understanding and practice presents heterosexuality as a privileged—and frequently the only—conceptualization of sexuality. LGB people experience *heterosexism*, an automatic assumption that all people

are heterosexual and where others speak and act in ways that assume a person is heterosexual. Consequently, the majority of healthcare education includes only minimal information about and for sexual minorities, and frequently it omits any information on how content or skills may apply to these groups. Heteronormativity "not only establishes a heterosexual/homosexual hierarchy, but also creates hierarchies among heterosexualities," [13] setting clear boundaries for how masculine and feminine men and women are supposed to present. Heteronormativity may make disclosing a sexual minority identity to a healthcare provider extremely challenging, particularly when the burden falls on the patient rather than the healthcare provider. For example, questions that may be asked of a heterosexual population (e.g., "How often do you have sex?" or "What methods of pregnancy prevention are you using?") may have little relevance to a sexual minority individual, with such questions requiring modification to make them more appropriate. The first question above implies sex as penetrative intercourse. Although some LGB persons may find penetrative sex enjoyable, not all would find it sexually satisfying or preferable. The second question assumes that a person is having sex that could lead to pregnancy and has limited meaning or relevance to many sexual minority individuals.

Heteronormativity also implies that all LGB persons desire the same life milestones and relationship goals as a heterosexual person in their similar sociodemographic. Within LGB cultures there are mixed perspectives on this topic, with some believing that some LGB people want to achieve such goals only to blend into privileged, white, middle-class standards, a phenomenon known as *homonormativity.* For many, these milestones represent personal decisions made with their partner(s). For example, a 2013 poll found only 51% of LGBT adults in the USA were either currently parents or wished to have children someday through donor insemination, surrogacy, fostering, or adoption [5].

Binegativity Bisexual individuals experience greater levels of stigma from both heterosexual and LG communities. As a culture that categorizes individuals by their relationships, bisexual identities are often invisible, and bisexual people are often incorrectly perceived as either gay or straight. Bisexuality has also been stigmatized as a non-existent identity—some heterosexual people believe that bisexual people are actually straight, temporarily experimenting, and ultimately will return to a heterosexual relationship, or they are simply viewed as more promiscuous and sexual in nature. Some gay and lesbian persons view bisexual people as indecisive and/or too scared or closeted to live their true life as gay or lesbian. Occasionally, individuals are unnecessarily concerned that their bisexual partner will be unfaithful to them with a person of another gender. Such discriminations fall under the umbrella term "binegativity," and despite evidence countering the above misconceptions, they persist.

Discrimination and oppression toward bisexual people are often unintentionally perpetuated by healthcare providers. In contrast with lesbian and gay persons, the attitude of binegativity discourages bisexual people from accessing healthcare. A study in the UK found only 33% of bisexual participants felt comfortable disclosing

their sexual identity to their healthcare provider [14], and a parallel study in the USA [15] found bisexual people significantly less likely to disclose their sexual identity, with 39% of bisexual men and 33% of bisexual women not disclosing their identities compared to 13% of gay men and 10% of lesbians. Less disclosure and increased stigma can affect the health and well-being of bisexual persons. For example:

- Though more likely to be tested for HIV, bisexual women also participate in riskier sexual behaviors such as having sex without barrier protection with an uncommitted partner.
- Bisexual men are at greater risk for contracting HIV but are less likely to get tested, resulting from decreased disclosure.
- Rates of human papillomavirus (HPV) transmission are elevated for bisexual men and screening rates lower for bisexual women.

Asking open-ended questions about partners in a non-judgmental way and allowing patients to self-identify promotes and encourages bisexual people to disclose their minority identity, directly increasing their likelihood of receiving the appropriate services for their sexual health needs.

Consensual Non-monogamy As previously noted, the perception of bisexual people as promiscuous and more likely to cheat is a common misconception. Approximately 3.5–5% of the general population currently practices *consensual non-monogamy* (CMN) [16], with about 20% of single adults reporting this practice at some point in their life [17]. CMN is a broad term used to describe open relationships, polyamory, swinging, and other relationship agreements between a person and more than one partner [18]. Although researchers do not know the number of LGB people who participate in CMN, both bisexual persons and those practicing CMN experience stigmatization surrounding (the lack of) consistency of sexual partners, engaging in risky sexual behaviors, and having STIs. Thus, bisexual individuals participating in consensual non-monogamy are less likely to seek and receive comprehensive healthcare. Further, assumptions about bisexuality as a means to non-consensual non-monogamy persist, creating a volatile narrative where the specific health needs of bisexual non-monogamous individuals, such as more consistent STI/HIV testing, may go unmet.

Frequent Negative Experiences with Healthcare Providers Little research has been conducted globally on LGB experiences of discrimination, harassment, marginalization, and violence in the health care system. At a 2013 World Health Organization (WHO) Executive Session, several countries (the USA, Brazil, and Thailand) asked for LGB health care needs to be placed on the agenda, but other countries (in Africa and the Middle East) specifically asked for the agenda item to be removed, citing no health disparities between LGB citizens and non-LGB citizens [18]. Countries in opposition cited LGB needs as a political rather than a health

issue, and by bringing attention to the discussion, argued it would damage public health. No further conversation has been held on these needs.

One can surmise then that while many countries share the opinions and perspectives of the US healthcare community, those in opposition may treat LGB patients poorly. Although little is known about the global situation, some data are available regarding the treatment of LGB patients by healthcare providers in the USA. Medical providers' comfort level treating LGB patients indicates an overall positive trend, with 82% feeling comfortable in 2007 [19] compared to 60% in the mid-1980s [2]. Discomfort with treating LGB patients often means that providers lack the basic knowledge to treat the health needs of LGB people and even implies that the person's sexual orientation may at times be the perceived reason for the presenting problem.

Despite increasing trends around providers' comfort level, LGB patients continue to report discrimination and heterosexism. Even in more accepting countries, 8% of LGB respondents indicate that healthcare provider refused to see them because of their actual or perceived sexual orientation, 6% reported that a healthcare provider refused them health care, and 7% reported that the healthcare provider refused to recognize their family, such as a spouse, partner, or child [20]. Alarmingly, some LGB patients reported experiencing aggressive or violent behaviors from their providers: 9% reported being talked to harshly or abusively and 7% experienced unwanted physical contact (e.g., rape, sexual assault, or fondling). To avoid discrimination and maltreatment, LGB patients often adopt a strategy of delaying or avoiding seeking health care, despite a medical necessity. Patients who experienced discrimination in the past year by a healthcare provider were seven times more likely to avoid an office visit than those who had not experienced discrimination (18.4% vs. 2.7%). Discriminatory healthcare practices are more common in rural areas, where LGB clients may find it a challenge to locate accepting or tolerant healthcare professionals.

Common Misconceptions by Healthcare Providers LGB patients face inaccurate assumptions and biases about their lives and health needs, including the type and quantity of sex they engage in. Gay men are falsely believed to have more partners and overall more sex; lesbian women are assumed to desire mainly penetrative sex; and bisexual persons are often stigmatized as sexually promiscuous.

Unfortunately, open and accepting healthcare providers are not always available for LGB clients. Approximately 17% of LGBTQ people feel it would be very difficult or impossible to receive the same quality of service at a different clinic, community health center, or hospital compared with their current provider [5]. For those living outside metropolitan areas, the problem is greater, with approximately 31% reporting that it would be difficult to access quality healthcare at community health centers or clinics, and 41% at a different hospital. Discrimination has real medical consequences, as it is known to lead to fewer preventative screenings.

Due to the lack of comfort in seeking care and/or past negative experiences with providers, LGB people are at increased risk for certain types of cancers. Lesbians have breast and cervical cancer screenings less often than peers [21, 22] and, despite having multiple risk factors [23], many lesbians underestimate their risk for cervical cancer [24]. Similar screenings are necessary for men who have sex with men (MSM) to appropriately treat HPV, especially for men who are HIV positive [25]. Decreased and delayed testing may result in advanced stage cancer and increased mortality rates in these populations.

Absence of Comprehensive Sex Education Sex education is another area of critical need for LGB populations. Current global standards for sex education are nonexistent, although some countries such as Switzerland have affirming and inclusive sex education. Other countries such as the USA have taken the initiative to suggest what should be taught to youth [2], but most curricula in US education systems [26] as well as in other nations (New Zealand, South Africa, India, China, etc. [27–31]) do not adequately address the needs of sexual minority youth, place little value on discussing content related to LGB issues, and even invalidate or degrade youth who identify as LGB. In less developed parts of world, recognition and discussion of sexual minorities is often absent and in some instances forbidden by the religious culture and even criminalized. Youth whose families have immigrated to more progressive countries, such as the USA, Canada, and most of Europe, may find themselves torn between their family's cultural standards and expectations, and those of the open, more tolerant culture.

Now more than ever, youth obtain information about sex from sources outside school and family, often through the Internet. In the USA, Millennials and Gen Z generations have access to more resources than ever [24, 32] though it is not always accurate [33–35], often perpetuates common myths and stereotypes, and may not regularly be updated to reflect the latest clinical guidelines on sexual health [36]. In a 2005 study, an estimated 29% of adolescents 15–18 years old relied on the Internet to search for sexual health information [37], and with ever growing Internet use, this rate has increased over the past 10+ years. However, healthcare providers often are the first and only place LGB people receive accurate sexual health information.

LGB Health Needs in the Elderly Global research on the needs of LGB elders is virtually non-existent outside North and South America, but even this research lacks depth. A 2018 global report conducted by Sage, an LGBT elder advocacy and service organization, interviewed over 116,000 LGBT-identified participants over the age of 55 in 75 countries about experiences in their culture [36]. LGB elders were found to face widespread discrimination and marginalization in their countries. Because elders in many cultures expect to be cared for by family and community, they may avoid disclosing their sexual identity to others out of fear of harm. In some cases, LGB elders face such extreme discrimination that they choose to socially isolate themselves or are ostracized by others, creating risk conditions for

depression. For those LGB elders who have not disclosed their identity to their community, healthcare providers might consider some of the support strategies—without jeopardizing confidentiality—presented later in this chapter.

HIV/STI Rates Men who have sex with men (MSM) contract HIV at higher rates globally than all other sexual orientations [21, 24], although data may be unreliable because, as of 2011, 93 countries had failed to report any information on HIV prevalence. Due to criminalization, stigma, and discrimination, currently <2% of all global HIV funding is directed specifically toward MSM. A 2014 global study of 6000 MSM from 160 countries found homophobia, violence, and criminalization of homosexuality as significant obstacles to accessing services by this sexual minority [38]. Fewer than 50% of these men found condoms, lubricants, and HIV testing and treatment to be easily accessible. Data from as recent as 2016 show the highest rates of new infection occurring in young adults (20–29), with rates declining with age, calling attention to the need to educate young people about safe sex. Safe sex initiatives should target this specific population, and barriers to accessing pre-exposure prophylaxis (PREP) (e.g., Truvada, an effective HIV antiviral) need to be lowered.

4.5 Practical Implications

Challenges One of the greatest challenges to medical providers is the assumption of homogeneity of life events and experiences among LGB clients. The intersection of sexual minority status and other social determinants of health (e.g., economic factors, family support, and community acceptance) suggests the importance of a thorough assessment, particularly when diagnosis and treatment are related to health disparities faced by sexual minority patients. Providers need to be aware of their preconceived stereotypes and myths concerning the lives of LGB patients, and focus on the real life experiences.

As mentioned earlier, healthcare providers are often the first people from whom LGB youth and adults receive accurate information about sex, as most school-based sex education programs are limited in LGB-inclusive content [39]. LGB youth may have little or inaccurate knowledge about sexuality and, since many LGB people avoid healthcare providers, they may be delayed in receiving important health information, thus placing them at greater risk for STIs/HIV and pregnancy. As a result of a dearth of relevant information for LGB people, more time than usual may be required for a typical clinic appointment with an LGB person, or additional staff may be needed to assist with education and/or more detailed explanation.

A further challenge in some communities is LGB patient access to "inclusive" care within a reasonable distance. Inclusive sexual health care providers could facilitate the dispersal of information by explicitly stating on their marketing materials a willingness to see LGB patients and to promote knowledgeable care. Providers in clinics or hospitals who are unsure of or unwilling to treat LGB patients could offer

a list of inclusive providers for referrals, with the recognition that providers in countries criminalizing homosexuality may be unable to post information or provide referrals safely and confidentially.

Opportunities LGB people need to be empowered as the owner of their stories and experiences, an often foreign experience for many LGB persons. The high rates of discrimination and mistreatment by healthcare providers in the past bring an opportunity for the culturally humble healthcare provider to offer a corrective experience, change the narrative around health care services, and thus increase the inclination for this population to seek needed health care.

Sexual health providers can provide safe spaces for LGB patients, indicated by the use of brochures representing LGB couples and posted policies demonstrating inclusiveness. When it might be risky or dangerous for providers to identify as LGB-inclusive, providers could utilize word-of-mouth and networking with trusted members or allies of the LGB community. This approach will help patients develop the necessary comfort and trust for implementing suggested interventions and behavioral modifications that reduce STI/HIV transmission and pregnancy. Providers should be prepared to answer questions about testing, partner testing, available barrier methods for pregnancy and STI/HIV prevention, disclosing STI/HIV status, negotiating sex with partners, and sexual dysfunctions.

4.6 Implications for Practice

The level and intensity of interaction with the LBG community will vary greatly across regions of the world as well as regions within various countries. While not all healthcare providers need to be experts in the care of LBG people, most should attempt to develop an understanding of the kinds of issues relevant to sexual minority communities, and strive to the best of their ability to meet the healthcare needs of such groups in ways that ensure positive health outcomes. Some healthcare professionals who work more closely and consistently with sexual minority communities—those, for example, practicing in urban areas or neighborhoods/clinics serving concentrated populations—may benefit from more intensely focused training in the area of sexual minority healthcare, especially when the patients' reasons for seeking treatment are specifically related to sexual issues and concerns.

Communication Sexual healthcare providers should use open and non-judgmental language when conducting a sexual history assessment. The healthcare provider should avoid assumptions about the patient's experiences, partners, relationships, and sexual history, and be aware of any biased communication—verbal or nonverbal—that could be read as intolerance, disapproval, or disgust. The provider should attempt to align language with the patient's language. For example, if a client uses the term "husband" or "wife" to describe a relationship, although not legally married, the provider should accept the client's descriptor of the

relationship. Additionally, if the client uses one term to identify their sexuality, the practitioner should use that same term as they move forward. It may be appropriate to ask the client their gender pronouns and preferred names, and the provider may model this for the patient. However, in some cultures where language is gendered, clients may use different words to express their identity. Even if someone appears to identify as a certain gender, asking is always recommended. A small number of LGB patients may identify as a gender minority and use different pronouns or names than listed on legal documents. LGB people may also present as more masculine or feminine than stereotyped normative gender presentations and still identify with their sex assigned at birth. Their gender expression/presentation should not predicate a specific gender role in their sexual relationship. The provider should be cautious about conflating gender expression (i.e., how one presents or demonstrates their masculinity/femininity) with gender identity (i.e., how one identifies their gender).

As mentioned previously, some LGB people participate in non-monogamous relationships. They may also participate in *kink* or other alternative sexual practices. Practitioners should reflect on their own comfort level with these topics prior to their first meeting with a patient. Lastly, healthcare providers should refrain from asking unnecessary questions of the clients, their life, and their sexual health that are not directly relevant or helpful to patient care. Before asking any question, the provider should consider the purpose of the question, the way it is being asked, its intent, and the theoretical or empirical foundation for asking.

Manner/Expectations Due to previous experiences with healthcare providers, patients may anticipate insensitive comments, micro-aggressions, discrimination, and/or violence, and be concerned about the level of knowledge of the provider. Even well-trained medical providers make mistakes with clients. By using a patient-centered approach, providers can build a trusting relationship that improves satisfaction and reduces the consequences of missteps. However, should a negative encounter occur, the healthcare provider should:

1. Apologize for misspeaking, misunderstanding, or stereotyping;
2. Ask the patient for more information in a non-judgmental, open-minded manner that allows the patient the opportunity to speak from experience;
3. Correct the behavior, thoughts, or feelings in future encounters with this and other patients as applicable.

Healthcare providers may also need to play an important role within their larger department, unit, or clinic. Staff and other colleagues may need to be educated about appropriate language, verbiage, and questions for this client population. If a provider witnesses discrimination or harassment, whether or not intentional, between a colleague and patient, the onus lies on the culturally informed provider to inform and correct the colleague and, if possible, ensure reparative action. This strategy can help defuse tension surrounding the encounter, re-establish a more

constructive relationship, and provide the patient with hope for future positive encounters.

4.7 Assessment

Providers should consider asking specific questions of sexual minority individuals. The following assessment plan is organized by content area and provides a suggested flow of questioning from least invasive to greater detail.

Sexual Identity History When asking about sexual partners, the provider should use a series of questions to gather information. The provider may begin by asking about sexual identity, "What's your sexual identity/orientation?" and regardless of the patient's response, follow up with, "At any point in your past, have you had sex with men, women, or individuals of another gender?" Table 4.1 provides suggested questions about sexual orientation. Table 4.2 provides alternative or additional questions to ask youth.

Sexual Activity/Sexual Behavior Sexual activity is defined more broadly than merely penile–vaginal intercourse. Patients should be asked about all types of sexual activity. Providers should explicitly ask about participating in kink or alternate sexual practices, consent in participating, and safety within the relationship. Questions about engaging in kink or alternative forms of sexual expression and consensual non-monogamous relationships should not imply the client's behavior is deviant or abnormal.

Furthermore, due to the increased risk of trauma and interpersonal violence, a thorough trauma and safety history should be conducted, including explicit questions about current partner safety. Further, LGB patients with a history of homelessness are more likely to have participated in sex work, often exchanging sex for a place to stay. Table 4.3 provides sample questions for discussing sexual activity.

STI/HIV Status LGB patients should be asked about their STI and HIV history at the initial assessment. Additional questions should be asked about risky behaviors that increase the likelihood of transmission, such as unprotected sex and intravenous drug use. Some MSM may not answer questions honestly about partner gender in regions where the act may be criminalized. When assessing risk factors for HIV, the provider should explicitly ask if the client has had any sexual encounters that increase risk for contracting HIV, such as giving and receiving oral sex from other men. Table 4.4 provides examples.

Sexual Dysfunction Across Partners Medical providers who are assessing sexual dysfunctions should consider several additional factors for LGB patients. The ICD-10 requires clinicians to specify "situational vs. chronic" for all sexual dysfunctions.

One situation to explore, especially for bisexual clients, is the role of partner gender on the sexual dysfunction, and the role of partner acceptance. The second specifier, "lifelong vs. acquired," requires the sexual health provider to consider all major life events. When mapping out a timeline for the development of the dysfunction, the patient should be asked explicitly about coming out (or being outed), family response to sexuality/level of "outness," partner response to sexual identity, partner response to sexual behaviors, interpersonal violence, transmission of HIV or another STI, and acts of violence, harassment, discrimination, or micro-aggressions. Table 4.5 includes a detailed, but not exhaustive, list of potential questions.

4.8 Diagnosis/Treatment

After completing the assessment, the provider should coordinate appropriate referrals for treatment. Sexual health providers need to carefully assess the role of the patient's sexual orientation in their presenting problem. There may be other co-occurring mental health diagnoses such as major depressive disorder, generalized anxiety disorder, or post-traumatic stress disorder resulting from a lack of acceptance or support, discrimination, and traumatic experiences. If the sexual dysfunction has a prominent psychological foundation, a referral to a mental health provider should be implemented. Clinicians certified by the American Association for Sexuality Educators, Counselors, and Therapists (AASECT) are considered the gold-standard providers for sex therapy and are available worldwide. If no AASECT certified counselor is available locally, a clinician who is at least minimally trained in sexual dysfunctions and LGB mental health may be adequate. The patient may require both individual and relationship therapy to address the root causes of the sexual dysfunction.

When working with patients who are asexual, providers should be cautious when diagnosing the patients with sexual aversion disorder or low sexual desire disorder. The provider needs to carefully rule out the clients' feelings about sex, interest in sex, and sexual trauma history as potential causes. Sexual health professionals should also be informed about harm reduction approaches to treating STIs/HIV. LGB individuals should be offered testing at patient wellness checks or every 3 months, depending on the patient's needs. Ideally, condoms and other barrier methods of protection should be available in clinics serving LGB clients due to the risk of disease transmission. Men who have sex with men (MSM) should be educated about the current standards regarding the pre-exposure prophylaxis, Truvada—a drug that prevents HIV transmission with minimal risk and side effects—and offered a prescription if they are interested.

4.9 Summary

Lesbian, gay, and bisexual patients require a lifespan approach to their sexual health needs. Conducting a thorough and comprehensive assessment in a non-judgmental manner improves the quality of patient care. Further, reducing psychosocial barriers

Box 4.2: Key Take-Aways

- Even if you are an expert of LGB health needs, it can still be easy to make a mistake. By using a patient-centered approach, you can build rapport and re-establish a healthy working relationship with your patient(s).
- If you have the time, conduct a thorough sexual history on your patient. There are certain questions you should ask your patient about their partners, protection, and level of outness that can help assess your patients' real needs.
- There is limited research on LGB health needs worldwide, so healthcare providers should understand that not all information provided in this brief chapter can be applied.
- LGB patients are at greater risk for facing health disparities. By creating a safe and supportive environment, educating about sex and safer sex practices, and supporting your clients, healthcare providers can significantly reduce health care disparities.

to care, such as education about sexual health, relationship building between providers and patients, and understanding the role of the patient's identity in their presenting problem, can improve the patient's willingness to seek and receive care, as well as satisfaction with their overall care. A list of important takeaways is summarized in Box 4.2.

4.10 Case Examples

The following case examples are intended to help the healthcare provider reflect on some of the kinds of issues that might arise in working with members of sexual minority groups. How might these patients respond if they are LGB?

Example 1 Rashawn arrives for his appointment and the front desk receptionist asks for his pronouns. During his sexual history, Rashawn is asked if he "has a girlfriend." This inquiry is inappropriate because providers should inquire about significant others using neutral language. Words like "partner" or "significant others" allows the patient to use their own language to describe their relationship. It also allows individuals with multiple partners to answer honestly.

Example 2 Mone has an appointment with her OB/GYN to get a pap smear. Mone is being seen at the local Pride Clinic and has an openly queer provider. Her gynecologist has not attended any cultural competency continuing education since medical school 10 years ago, because she believes as a queer person, she already understands the landscape of sexual minorities. The gynecologist asks, "Are you sexually active with men, women, or both?" to which Mone responds, "I have one partner. She's a woman." Assuming it unnecessary, the physician does not follow up

about protection. Regardless of the partner's identity, patients should be asked about methods of protection. Perhaps her partner is a transwoman who has not had bottom surgery, and condoms may need to be used. Her partner may also be another cis-woman, and she may benefit from using dental dams during oral sex.

Example 3 Muhammad is meeting "their" wife, Archna, at her first prenatal appointment. Muhammad identifies as gender non-conforming and was assigned as male at birth. Muhammad presents as very feminine, and uses they/them pronouns. The obstetrician introduces himself and greets Muhammad, "Hi, are you here to support Archna?" Muhammad responds, "No, I'm her partner." The obstetrician responds, "Sorry! I didn't know you were her wife." This response is inappropriate because this may not be how Muhammad identifies themselves in their relationship. Muhammad may still prefer the term husband, wife, or some other terminology. Muhammad also used the term "partner," which may actually be the term they most identify with.

Example 4 Jayleen, a Latinx pansexual woman, is at the office of her primary care provider. While waiting for her appointment, she browses through several brochures and notices the pamphlets are only available in English and they feature white, seemingly heterosexual, people, except for the brochure on STIs/HIV that shows only people of color. The pamphlets present two problems: inaccessibility for patients where English is their second language, and stigmatization of people of color as the target audience for HIV and STI prevention. While racial/ethnic minorities are at greater risk for transmission for HIV, people of color should be present in other brochures.

Appendix: Tables

Table 4.1 Sample questions to gather information about sexual orientation

What's your sexual identity/orientation?
At any point in your past, have you had sex with men, women, or individuals of another gender?
What are the genders of your current partners?
Are you currently having sex with all of your partners?

Table 4.2 Additional questions to ask adolescents

What questions do you have about your body, sex, or relationships?
Patients your age are exploring new relationships. Who do you find yourself attracted to?
What do your parents know about your sexuality?
What can I do, if anything, to help tell your parents/support you?

Table 4.3 Sample questions about sexual activity

People can have sex in several ways. Have you ever had sexual intercourse?
Have you ever received oral sex? Given?
Have you ever been the receiver of anal sex? Given?
Have you been sexually active within the last year?
If no: Have you ever been sexually active?
How many sexual partners have you ever had? (Ask question for each gender of partner)
What types of protection do you use? (e.g., condoms, dental dams, IUD, etc.)
If none asks, There are lots of reasons why people don't use protection; what might be your reasons?
When do you use these protections? With which partners?
For women, Are you currently trying to get pregnant?
Have you ever exchanged sex for drugs or money?
Have you or any of your partners used alcohol or drugs when you had sex?
Have you ever been coerced or pressured to have sex?

Table 4.4 Sample questions about STI/HIV status

Have you ever had a sexually transmitted infection (or disease)?
If yes: Which STI? Where was the infection? When did you have it? Was (were) your partner(s) treated too?
Have you ever been tested for HIV?
If yes: How long ago was that test? What was the result?
Have you been vaccinated against HPV? Hepatitis A? Hepatitis B? (*If unavailable in the chart)*

Table 4.5 Sample questions to assess sexual dysfunction

Does the problem happen with all partners, regardless of gender?
Did the problem develop before or after sexual encounters with one gender?
Did the problem happen before or after coming out to a parent?
How does your partner feel about your sexual orientation?
If HIV+ or on PREP, Did the problem happen before or after starting your anti-retroviral/ diagnosis?
How do you feel about your sexual orientation?
If experienced trauma, What role, if any, does your trauma play into your sexual experience?

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Transcultural Homo- and Transphobia

5

Giacomo Ciocca, Caterina Solano, Filippo M. Nimbi, and Emmanuele A. Jannini

5.1 Introduction

Negative attitudes toward homosexual and transsexual people are grounded on a number of reasons, ranging from sociocultural to psychological issues. Education, political and religious beliefs, and life experiences undoubtedly play pivotal roles. However, various factors weave together to cause discriminatory behavior toward lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, with such discrimination currently identified as homophobia and transphobia. Moreover, those exhibiting sexual and gender variations are often ostracized by various components of society: schools and work places as well as health services. Thus, despite Western media attention often aimed at diminishing homophobia and transphobia, negative attitudes and behaviors toward LGBT people persist, and may have actually increased due to expanded coverage of the issue. Therefore, homophobia and transphobia prevention campaigns need to employ rigorous methods that include assessing possible risk factors that give rise to homophobic and transphobic attitudes and behaviors within culturally defined contexts. In this regard, an accurate and specific sociocultural and transcultural reflection should be undertaken so as to prevent discrimination of sexual minorities worldwide.

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5.2 Definitions of Homophobia and Transphobia

Homophobia, a term coined by Weinberg, was originally defined as the irrational fear, hatred, and intolerance of homosexual men and women by heterosexual individuals [1]. More generally, homophobia is the tendency to discriminate against homosexual people through psychological and social aversion and, in some cases, through acts of violence. However, some studies, controversially and perhaps hypothetically, have preferred the term "homonegativity" in order to avoid overlapping and perhaps conflating terminology with actual "phobic" symptoms (referring to a psychological health condition) and to distinguish this negative attitude from the sense of fear toward something/someone [2, 3]. Whatever the case, certain psychosexological issues such as dysfunctional personality traits or latent attraction toward same-sex individuals by heterosexual people have been associated with homophobic phenomena [4, 5]. Although some may argue that homo- and trans-negativities are relative, being simply a matter of taste and not relevant to sexual medicine, homo- and transphobias sometimes underlie violent behaviors and crimes toward specific individuals and therefore are very much related to the sexual health of the population.

Scientific attention toward homophobia/homonegativity increased in 1983 following the nosological revisions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). In fact, in that year, homosexuality was removed from the list of mental health problems, indicating greater social recognition and decreasing stigmatization of homosexuality by the medical community [6, 7]. Similar to homophobia, transphobia was originally defined as the fear, discrimination, or hatred against transgender or non-binary gender people. To date, the International Statistical Classification of Diseases and Related Health Problems (ICD-11) removed transsexualism from the section of mental disorders, placing it in the section dedicated to sexual health after one study convincingly demonstrated that psychological distress in transgender people was mainly a consequence of discrimination and stigmatization [8, 9].

Transphobia and homophobia are linked because both are forms of stigmatization against sexual minorities (LGBTQ community), and the sociocultural processes underlying them are similar, though not completely identical [10]. Such issues concern every country worldwide and occur in nearly every type of social environment, including schools, churches, political authorities, health care, and work [11]. The diffusion and increase of homophobic- and transphobic-related behaviors have inspired researchers and activists to delve more deeply into the psychological, cultural, and social motivations responsible for these negative attitudes, with added attention to aspects of transculture.

5.3 Sociocultural Factors

A large part of the psycho-sexological literature considers homophobia and transphobia as a product of culture, where social, political, and religious aspects play a dominant role [11]. Homophobia and transphobia, in fact, have been seen as a

socially pervasive and collective prejudice perpetrated within societies where there is a strong sexual stigma against sexual minorities. The terminology "sexual stigma" is used precisely to denote the set of negative beliefs shared in society toward those who are not heterosexual. Stigma has been defined as a strong disapproval toward characteristics that an individual possesses (or that he/she is believed to possess) that are considered socially inappropriate [12]. Homophobia, in fact, is not a universal attitude that affects all individuals or all societies, as differences in degree occur across political, social, and religious ideologies [13]. Therefore, a sociocultural approach toward issues of sexual discrimination is important.

The LGBTQ population is particularly at risk for sexual stigma as it does not conform to the hetero-normative cultural expectations for sexual orientation and gender identity expressions [14]. Specifically, homophobia describes negative attitudes toward individuals who are not exclusively heterosexual [15], and transphobia, toward those who differ from the common standards of gender dichotomy (male and female). Both these phobias can be expressed in different modes and intensities [16]. However, sexual stigma affects not only people from the general heterosexual population, but also members of the LGBTQ community, giving rise to the concept of internalized homophobia and transphobia [13].

In this regard, the role of religion in sexual stigmatization has been explored in several studies, generally demonstrating that those who hold extremist and conservative views in matters of religion are more likely to express sexual prejudice [12]. In a study of US college students, conservative protestants were the most negative in their attitudes toward homosexuals, while students who were atheist, agnostic, Jewish, or claimed no religion held positive attitudes [17]. Similarly, an Italian study has confirmed that religious fundamentalism and rigid religious beliefs are associated with homophobia and transphobia, and not, as conventionally believed, with a specific religious affiliation [12]. However, a multinational survey conducted by Transgender Europe (TGEU) in the Philippines, Serbia, Thailand, Tonga, Turkey, Venezuela, and parts of Colombia and India revealed that religious acceptance of trans people can be attributed less to different religions per se, and more to the particular social and cultural context [18].

In reference to political affiliation, some scholars have shown that a strong conservative ideology (right-winged, nationalistic) is more often associated with homophobic attitudes [11, 19], while others have shown a similar trend in post-communist societies [11]. Therefore, the effects of religion and politics on attitudes toward sexual minorities may be influenced primarily by the cultural mores of a country. For example, Eastern European countries generally show higher homophobic levels than Western ones [11]: a study on students from three different European countries (Albania, Italy, and Ukraine) found that Ukrainian students reported the highest levels of homophobic attitudes. In addition, Ukrainian law has condemned homosexuality since 1991, and to date a large part of that population continues to be anti-gay [20]. In Albania as well, homosexuality was illegal and punishable until 1995, and these jurisdictional aspects influenced the attitudes and prejudices toward LGBT people [21].

In the Italian context, the long-standing coexistence of a strong Catholic culture alongside a tolerant Mediterranean one has reinforced the diffusion of an attitude

referred to as "don't ask, don't tell" related to homosexuality [22]. This attitude has led Italian gay men and lesbians to hide their sexuality, as it is better tolerated when not publicly expressed [19]. These actions reinforce the invisibility of LGBTQ individuals and, at the same time, indirectly promote acts of discrimination and violence against them [23].

Other interesting evidence derives from the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), an organization established to safeguard LGBTQ people. ILGA compared attitudes toward sexual and gender diversity based on religious beliefs and cultural mores, with two fundamental questions in the transcultural survey: "Is it possible to respect my religion and be accepting of people who are romantically or sexually attracted to people of the same sex?" and "Is it possible to respect my religion and be accepting of people who dress, act or identify as one sex although they were born as another?" [24]. Data from this survey revealed few differences regarding the acceptance or non-acceptance of same-sex vs. transgender diversity. In other words, the prejudicial approach toward homosexuals and transsexuals was similar, both being driven by religion and culture. Moreover, Americans were generally more tolerant than African and Asiatic peoples, supporting the relationship between respect of religious belief and the approach toward gender and sexual diversity [24]. Similar responses, and therefore a similar effect, have been noted regarding the relationship of cultural mores and attitudes toward homosexuality and transsexualism (Fig. 5.1).

5.4 Laws and Attitudes Toward LGBTQ People Across the Continents

In a second report relevant to this topic, ILGA provided extensive information about LGBTQ legislation in different countries. Homosexuality is criminalized in about 70 states, with penalties ranging from years in prison, to torture, and to death (Fig. 5.2) [25]. ILGA also generated a map illustrating legislation related to homosexuality, with the continents of Africa and Asia showing the most severe penalties for homosexuality. The death penalty, effective or possible, is legislated in 11 countries [25]. In addition, the influence of religion on civil codes appeared most obviously in some African and Asian countries. Differences were noted in Europe as well, with a substantial division between Western and Eastern Europe and a mild regional variation in Western Europe identified in the Mediterranean area. In Western European countries, legal rights of homosexuals are given greater recognition, as exemplified by condoned marriage, while in Eastern Europe, homosexual people still experience legislative discrimination or unrecognized rights. The Mediterranean area occupies a middle position, where some rights have recently been recognized for homosexual people, such as allowing civil unions. Moreover some countries—Canada, Australia, South Africa, vast parts of West and North

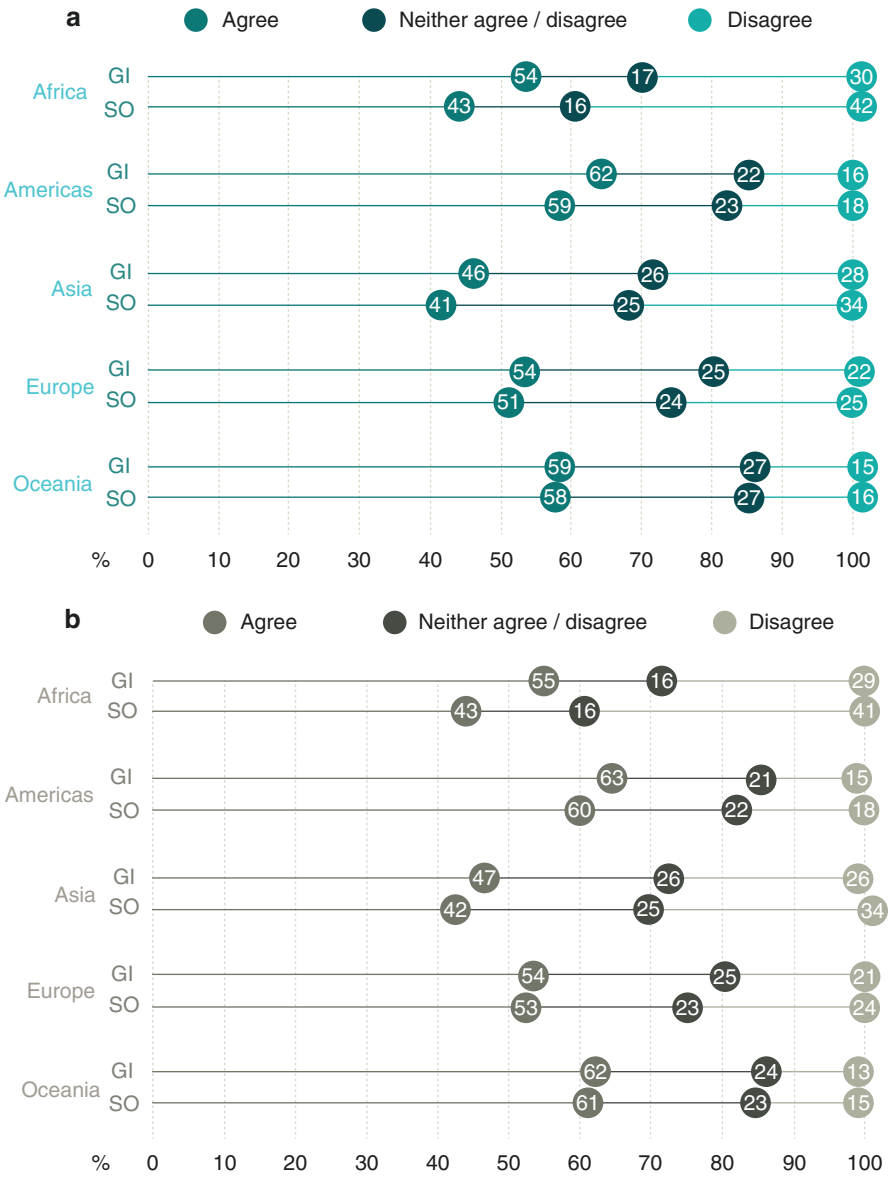

Fig. 5.1 ILGA's report revealed the attitudes toward homosexual and transsexual people based on the respect of the own religion (**a**) or culture (**b**). Small or no differences about the attitude toward gender identity (GI) and sexual orientation (SO) are shown, while differences between continents are documented [24]

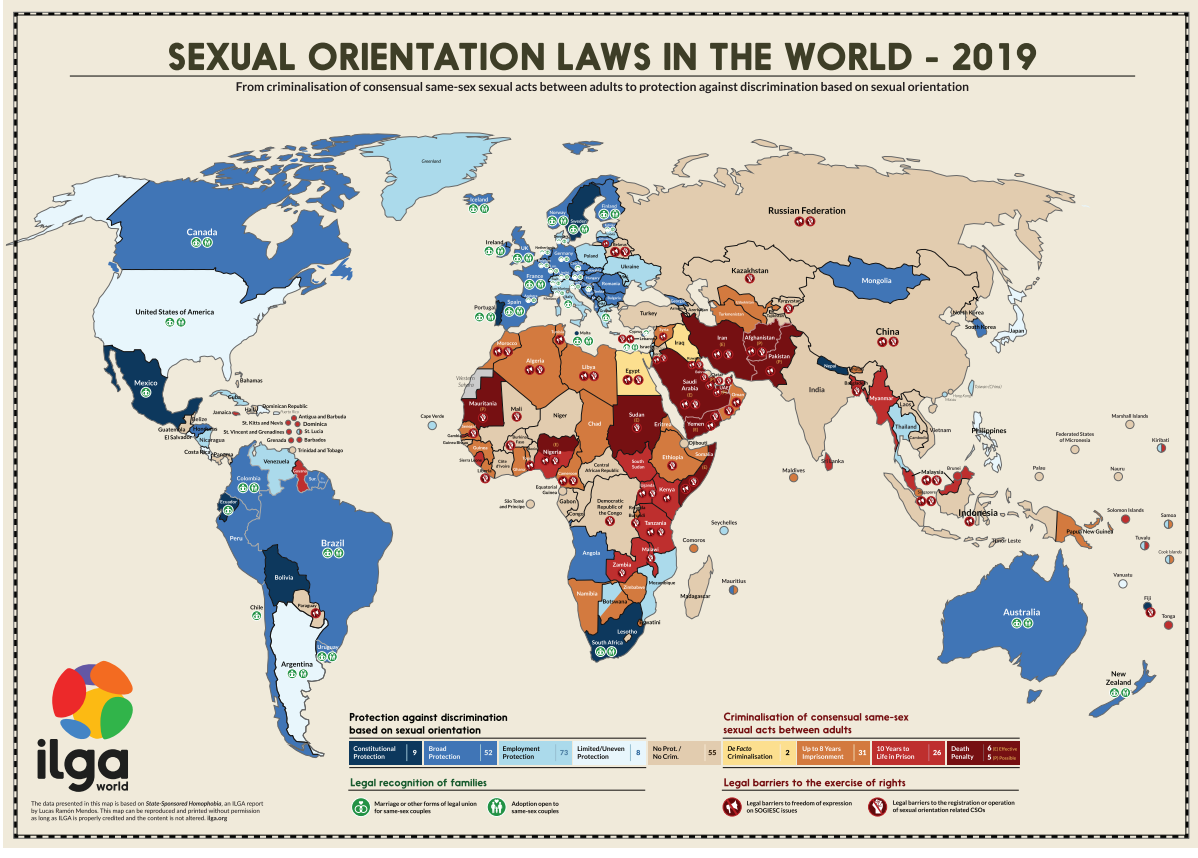

Fig. 5.2 ILGA's report about the laws in favor or against homosexuality. In some states homosexuality is criminalized, in others homosexuals have the same civil rights than heterosexuals. In the regions with a blue on color, more civil rights are recognized to homosexual people [25]

Europe, and parts of the USA and parts of Latin America—allow adoption and parenthood by same-sex couples [25].

ILGA describes the possibility of changing names and sex-gender markers on official documents to respond to transsexualism and gender dysphoria [26]. Some jurisdictional procedures have established various criteria and requirements specifically for this purpose. Among these criteria are a medical and psychiatric evaluation according to the DSM-5 [27] or the more recent ICD-11 [8], and evidence of real-life experiences whereby people seeking the legal sex change must experiment and fully live in their desired gender role. Some countries concede to name and sex marker changes only after surgical body modifications (surgical reassignment of sex). In some situations, obtaining a legal sex change may involve sociodemographic aspects, such as being married or a parent. In such cases, divorces are mandated if the transsexual individual was previously married and the relational status was based on the biological sex. These procedures obviously differ among countries and in part reflect different sociocultural environments [26]—further evidence that culture and religion play an important role in influencing each jurisdiction's legislative concessions to rights for LGBTQ people. Such sociocultural and jurisdictional aspects are, therefore, linked to discriminatory beliefs and homophobic and transphobic attitudes.

In this regard, a European report distributed by the European Agency for Fundamental Rights identified those countries in which homophobia is considered an aggravating factor of criminal offences. In only 10 of 28 European states homophobia is an aggravating factor, demonstrating little jurisdictional attention in those areas toward sexual minorities and their protection from discrimination and violence [28]. These cultural biases along with unrecognized rights could play a

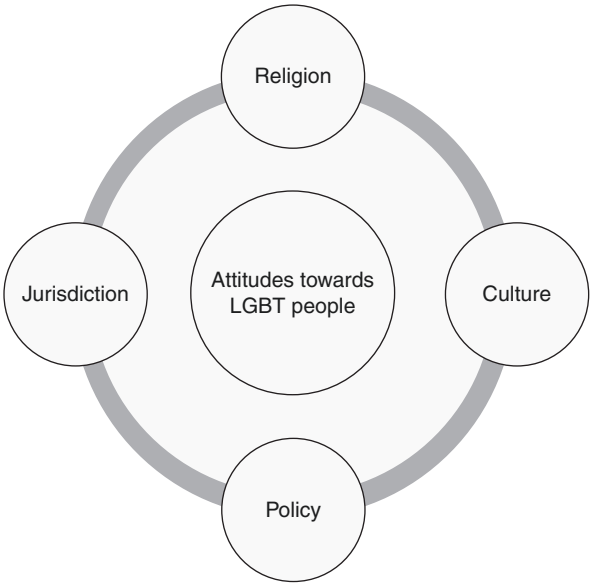

Fig. 5.3 Transcultural attitudes toward LGBT people are cause and effect, at the same time, of a mutual influence among jurisdictional, religious, cultural, and policy aspects

central role in the cycle consisting of mutually influencing jurisdictional, religious, sociocultural, and policy aspects (Fig. 5.3).

5.5 Gender Differences and Gender Issues Across Cultures

Psycho-sexological studies have for the most part indicated that homophobic attitudes toward homosexuals are more common among men than women [12, 29, 30]. Compared with females overall and heterosexual males of other age groups, heterosexual males in their late teens and early twenties have been found to exhibit the most violence toward homosexuals [31]. Along the same lines, an Italian study highlighted that male university students showed a number of characteristics, including: higher homophobic attitudes, both general and with respect to more negative cognitions; more negative affects; and an increased risk of aggressive behavior toward homosexuals [4]. This study further demonstrated that nationality was not a mediating factor, as men were generally more homophobic independent of culture or nationality [11]. Similar results have been found regarding transphobia. Heterosexual men tended to rate gay man more negatively than lesbians, while heterosexual women's attitudes toward gays and lesbians did not differ [32]. One interpretation of these male–female differences suggests that men have a higher general adherence to traditional gender roles [12], with "gender roles" referring to the outward expression and demonstration of gender identity through norms, behaviors, and culturally determined expectations of femininity and masculinity. Hence, homophobic acts might function to help establish a rigid dichotomy of gender roles based on a deviant masculine ideology [33], an idea further supported by findings that negative attitudes toward homosexuals and transsexuals are linked to strong beliefs about traditional gender roles [22, 30, 32].

Individuals from any culture who support traditional gender role beliefs and adhere fairly strongly to a sexist ideology tend to hold more negative attitudes toward LGBTQ individuals, as non-heterosexual behaviors often break the rules of traditional heterosexist belief systems, no matter what the culture [30, 34]. Heterosexual men with a strong adherence to an unambiguous gender identity may see homosexuality as a threat to traditional gender roles [30]. Conversely, heterosexual female gender roles tend to be more flexible than are male roles. However, heterosexual women who feel that unequivocal feminine traits are important to their personal identity tend to be more homophobic than other women [35].

The typical pattern of heterosexual men showing higher levels of homophobia than women could be explained by men's greater adherence to traditional gender roles, occurring for any number of reasons, such as men having received more rigid education based on traditional gender roles or because most cultures confer more power and privilege on men than women. In addition, in many cultures and religions, the female role is discriminated against [36, 37]. However, biological and cultural frailty of males may also account for the mentioned gender-related differences in phobic beliefs and behaviors toward homosexuality and

transsexuality, as well as for their more hostile attitude toward male non-conforming sexualities (vs. female non-conforming sexualities). Moreover, it could be argued that homophobic and transphobic attitudes toward LGBTQ people reflect beliefs about rigid gender roles traditionally and socially defined on the basis of cultural roots. For these reasons, negative stereotypes about and discrimination against LGBTQ people by heterosexual men (and women) could be countered by addressing sexist attitudes and increasing heterosexual's contact and integration with homosexual individuals [38].

5.6 Discrimination and Impact on Mental Health

Discrimination and acts of physical and/or verbal violence toward LGBTQ people place this population at greater risk for mental distress [39]. The minority stress model [40] states that LGBTQ individuals, by nature of their status as minorities in society, experience stressors that have deleterious impacts on their physical and mental health. According to this theory, the primary sources of minority stress are the perceived stigma and the consequent reaction of refusal, experience of discrimination and violence, and "internalized homophobia or transphobia." Internalized homophobia refers to the reactive feelings of distress and depression as well as the suicidal thoughts commonly found among homosexual people, often the direct expression of a homophobic culture [41].

Because of discrimination, LGBTQ people generally show an increased risk for acute stress, depression, anxiety, or substance abuse [39], with research demonstrating, for example, that homosexuality constitutes a risk factor for suicidal attempts, with a rate twice that of their heterosexual peers. In the transsexual population, increased risk occurs for mood disorders, anxiety, eating disorders, and suicide, with the latter higher in transsexual males (FtM) than transsexual females (MtF) [39].

Based on a major epidemiological study, a similar trend was observed in the bisexual population, with a strong connection between bisexuality and higher rates of psychological problems compared to other sexual orientations, including same-sex orientations [42]. Bisexual individuals also have an increased risk of suicidal behavior (both ideation and attempts), and substance abuse and dependence, than either heterosexual or homosexual people [42, 43]. The fallout of being bisexual was also demonstrated in a large British study on minority women that indicated a higher risk for poor mental health and mental distress in these women compared to lesbians [44]. Depression and anxiety disorders, as well as eating disorders, are also more frequent in these women relative to heterosexual or homosexual counterparts [45].

Among the psychological risk factors, social stress and social exclusion appear to have the greatest impact on various forms of suffering [46]. Specifically, discrimination and victimization related to non-heterosexual people, critical judgment of peers, and family rejection are factors that threaten LGBTQ people's health [47]. Finally, psychological suffering from homophobic and transphobic discrimination

is also related to parenting—not to the experience of being parents but rather to the direct or indirect experiences of stigmatization to which the children of such pairs may be exposed in their society [48].

5.7 Conclusion

In conclusion, it is essential that now more than ever—when many countries still persecute homosexual and transsexual persons and politicians mask, even in Western countries, their homophobic identity with subtle political/social messages about in-groups and out-groups—to promote awareness and acceptance of LGBTQ people. In this regard, researchers, activists, and enlightened politicians need always to consider and respect differences among cultures, civilizations, religions, and countries when dealing with gender issues, yet they should also advocate for campaigns that safeguard the psychological and social health of LGBTQ individuals.

Classifying homo- and transphobia in future taxonomies (i.e., DSM-6 and ICD-12) of mental disorders and psychopathologies, with attention to the personal and social well-being of both the phobic person and the person who is the object of the phobia, as well as to the mediating environmental conditions, could help improve, transculturally, the sexual health of these populations.

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6 Impact of Chinese Traditional Culture and Related Social Norms on Current Chinese Sexuality and on the Future of Chinese Sexual Medicine

Elena Colonnello and Emmanuele A. Jannini

6.1 Introduction

Skyscrapers that tickle the clouds. Verticality, noise, lights, traffic, velocity. Since 1978, with its cultural and economic opening, rapid development and urbanization has taken place in China. Along with the socioeconomic changes, modernization and globalization have brought about refreshing ideas in a wide range of social issues. Sex ideologies are part of this evolving scenario, where traditionalism and open attitudes interlace in a complex and fascinating manner.

For example, while people born after 1980 seem to be more open compared with previous generations, traditional views about sex are still present even among young people. Attitudes toward premarital sex and masturbation seem to be, at least in some regions of the Chinese continent, more conservative compared to students in contemporary Western countries [1]. The ever-increasing influx of Western mass media and the global Internet culture have provided Chinese citizens with greater exposure to new attitudes, ideals, values, and lifestyles. However, a straightforward

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approach to the topic of sexuality is still not frequent within the Chinese context: metaphors are more commonly preferred to the explicit use of crude/street terms related to sex, through the traditional but always flourishing poetic perspective, distinctive of Chinese culture.

One interesting example is the history of the first (and so far last) China Sex Museum, opened by the sociologist Liu Dalin of Shanghai University, a pioneer of sex studies in China. First established in Shanghai in 1999 where it attracted few visitors, Prof. Liu's museum was re-opened in 2004 in the small town of Tongli in Suzhou, but closed again, probably not for moralistic reasons but for lack of interest.

So, where does this controversy take its root? And what further implications might it have for both psychosexologists and physicians dealing with medical sexology in China or with Chinese patients?

The following paragraphs aim to search for an answer to these and other questions, relating to the complex background of both *traditional beliefs* and *social norms* of Chinese culture and addressing them as valuable tools for overcoming culture-related health barriers (see Box 6.1). *Suo yang* ("shrinkage of penis") and *Shen kuei* ("kidney deficiency"), two culture-bound syndromes observed in China which share some psychopathological features and common misbeliefs, are reviewed as a specific example of the influence of those components. Other than the specificity of these two entities, more general implications for a management of sexual health in China are discussed (Fig. 6.1).

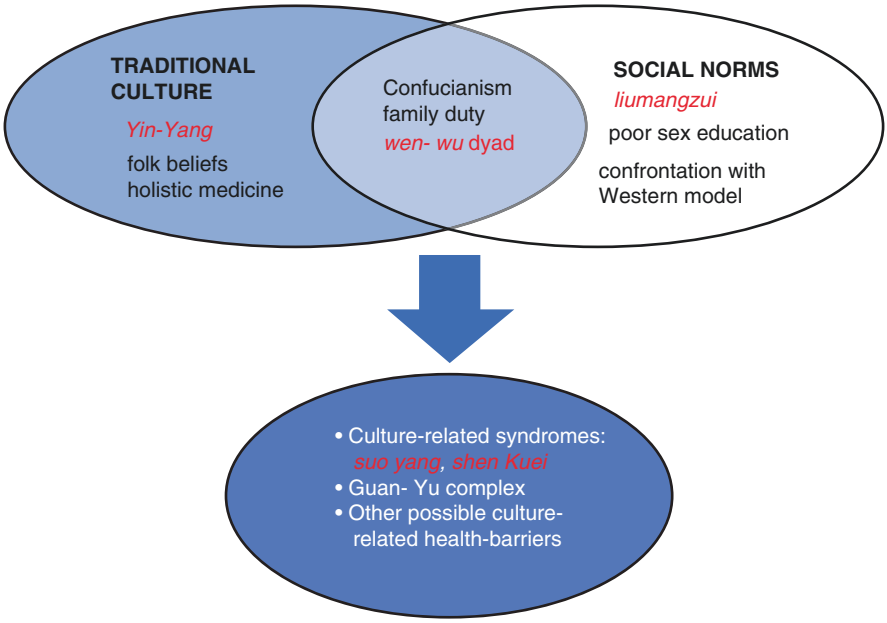

Fig. 6.1 Schematic representation of cultural background of Chinese milieu and its consequences on current Chinese sexuality. For the terms written in red, see Box 6.2

6.2 Beyond Signs and Symptoms: Cultural Background of Chinese *Koro*

The term *koro* indicates a culture-bound syndrome, predominantly prevalent in Southeast Asia and China, in which the individual has an overpowering belief that his or her sex organs are retracting and will ultimately disappear, often leading to death. This occurs despite the lack of any true longstanding changes in the genitals, or typical triggers like cold temperature and other organic, reversible causes of retraction in penis size [2, 3]. The history and description of the syndrome has intrigued psychiatrists, sexologists, and sociologists around the world for years, and various factors have contributed to shifting the focus of *koro* from being a regional issue to a globally acknowledged condition. Evidence suggests that *koro* is often found in association with comorbidities like drug abuse and other psychiatric disorders [4]. Also, various epidemics of *koro* have occurred outside China, major ones being in Singapore in 1967, Thailand in 1976 [5], and India in 1982 [6], and the call for a need for modern classification was fulfilled by the listing of *koro* in DSM-IV-TR as a culture-bound syndrome of delusional disorder [7]. A further reclassification has occurred in DSM-V, where the condition appears among the cultural concepts of distress, being related to the Dhat syndrome, a similar condition found in India and the Asian subcontinent [8]. However, the classifying of the syndrome into a modern framework can inadvertently neglect important context. Perhaps an approach that recapitulates the *traditional culture* background can be useful for a deeper understanding of the condition.

The term "*koro*" is a Malay word indicating the "head of a turtle" [9, 10], while its corresponding Chinese name is *suo yang*, literally "shrinking penis." Female cases associated with the fear of retracting nipple and breast have also been reported, but they constitute a minority among victims [11]. The syndrome often assumes panic features, with the patient experiencing profuse diaphoresis, palpitations, dizziness or vertigo, paresthesia, and feelings of numbness. The insuperable fear of a retracting penis often leads the anxious patient to dramatic, preventive maneuvers like holding his penis, pulling it outward and showing it to others for reassurance, or "anchoring" it with some clamping device or strings. Thus, physical injuries, self-induced or induced by others, are among the more commonly encountered complications, along with depression or overt erectile dysfunction [3, 10].

The severe anxiety associated with the perception that the genitals are retracting into the body has a long history in Chinese culture, being defined for the first time in *Huang Di Neijing*, the Yellow Emperor's "Classic of Internal Medicine," presumably written in the third century B.C [12]. The fear of retracting "yang," defined as the male principle, has been culturally linked with Taoism and the *Yin-Yang* concept (陰陽 or 阴阳), both pervasive in Chinese *weltanschauung* (Fig. 6.2).

According to Yin Yang philosophy, all objects and events are the products of two elements, forces, or principles:

– *Yin*: negative, passive, weak, destructive, cold, identified with the female figure and the nighttime.

Fig. 6.2 The *yin-yang* symbol. Note that the opposition between the two principles is balanced by a portion of each other, representing the complementarity between the two poles

– *Yang*: positive, active, strong, constructive, warm, identified with the male figure and the daytime.

This opposition manifests also in their corresponding simplified Chinese characters, as *yīn* and *yáng* combine the same "hill" radical 阝 with the non-phonetic *yuè* 月 "moon" and *rì* 日 "sun," meaning literally "shady side of a hill" and "sunny side of a hill." This concept, particularly embedded in Chinese philosophy, describes how apparently opposite vectors, yin and yang ("dark-bright," "negative-positive," and "disorder-order"), are sexually complementary, socially interdependent, and spiritually interconnected. The sexual allure is due to the assumption that the Yin is the female, receptive principle, while the Yang is the male, active principle, graphically depicted as a coital union.

Although the different social roles of women and men and their structural differences in sexual organs are undoubtedly much more than the result of these two forces, their opposition can explain also some basic concepts of Chinese sexual philosophy [13], for example, in the way the Chinese referred to organs and sexual behaviors for thousands of years: *Yin Fu*, literally "the door of Yin," indicated the vulva, while *Yin Dao* or "passageway of Yin and Yang," namely *Huo Yin Yang* or *Yin Yang Huo He* (Pan Shu's "History of the Former Han Dynasty") was quoted in [13].

In light of this doctrine, the woman is seen as an inexhaustible source of *yin*, while men have only a limited supply of *yang* [14]. Nocturnal emissions, masturbation, improper diet, or exposure to cold, which all cause a loss of *yang,* are therefore dangerous to the male's vital energy.

Taoism also explains that within the human body there is a kind of spiritual energy called *jing*, which resides in the kidneys, and too much sexual activity could

deplete it and hamper its circulation, as the elements of the reproductive and sexual system are linked with this spiritual energy [12]. Thus, attempts of explaining *suo yang*, the Chinese form of *koro*, often implicated the influence of Chinese traditional education and sexual philosophy, where parental warnings against masturbation and popular superstitions claiming not to eat too much *yin* food were the likely harbingers of the illness [3, 11, 15]. Modern interpretations implicating the Freudian castration anxiety fear [16] and parallelism with onanism [10] have also been proposed.

However, the link with Taoism seems not to adequately consider the following noteworthy issues. First is the occurrence of *koro* among female subjects, although less prevalent, and among non-Asian people, where the syndrome assumes slightly different characteristics. The fear of impending death is not claimed in these latter cases, but rather a concern for penis size and fear of impotence are noted, which can be explained by differences in the concept of masculinity between Western and non-Western cultures [9]. When *koro* occurs secondarily to other psychological issues like depression, drug abuse, schizophrenia, and other mental or somatic conditions reported by Western clinicians in *koro*-affected patients, it is classified as *secondary koro*, and the underlying conditions responsible for the symptom are treated [17]. However, even when *primary koro* is considered as a socioculturally determined issue, notable differences are seen in cases occurring outside China. For example, in Africa several sporadic cases of "genital theft panics" have been reported [18], where the issue of the penis being stolen rather than retracting into the abdomen represents the first evident difference. The fear of associated death also does not occur in these instances, but the implication of *juju* (witchcraft) represents a clear similarity with the Chinese *koro:* in both communities, the idea of sexual function and reproductive ability being jeopardized by the action of *magical powers* is stressed. Interestingly, interpretations of the epidemics of *koro* focused on, besides the symptomatology of the victim, the reactions of neighbors and community. Not only is the victim suffering, but people around him/her are frightened and try to help him/her. People *believe* in what is happening, reinforcing the idea of a culture-related syndrome rather than an exquisitely individual castration fear/anxiety or depersonalization disorder [11, 19].

The 1984–1985 and 1987 *koro* epidemics in Southern China have been investigated by giving questionnaires to 214 victims, 173 males and 41 females, and comparing the results with a group of 56 psychiatric patients and a control group of 153 people not affected by the condition nor by any psychiatric comorbidity [20]. Interestingly, while the three groups did not differ much regarding sex-related cultural beliefs (e.g., the belief that conserving semen is good for health), the most striking result was given by the "folk beliefs" section of the questionnaire in which *koro* victims showed greater belief in both *koro* as a condition in which sexual organs can retract into the bodies and cause death, and in supernatural powers. These beliefs are related to culturally predominant myths, as suggested by the fact that epidemics in China occurred among predominant ethnic groups of Han people and never among minorities like Li and Miao, who are likely to have a different traditional background [15, 19].

Description of the outbreak of *koro* in 1985 in Hainan Islands claimed the role of a fortune-teller who predicted the return of a fox spirit in the region, and the epidemic spread only where this belief was held [21]. The *Fox spirits*, or nine tailed foxes, are very common figures in Chinese mythology and literature, featured, for example, in *Shénmó Xiǎoshuō* (Gods and demons fiction), like the *Classic of Mountains and Seas* by Guo Pu, regarded as one of the Four Classics in Chinese literature, and the *Fengshen Yanyi* (Investiture of the Gods) novel [22, 23].

Fox spirits, also known as *húli jīng* in China, are creatures that have the magical ability to transform into humans, usually fascinating, attractive women who bring problems and troubles and finally destroy men, in some ways recalling the Homeric myth of sirens. One famous fox spirit is Daji, featured in the novel *Fengshen Yanyi* written during the Ming dynasty in sixteenth century by the Han writer Xu Zhonglin. In the novel, Daji is the favorite concubine of King Zhou who is obsessed by her and performs many acts of tyranny to ingratiate himself and please her. But in reality she was possessed by a nine-tail fox spirit sent by Nüwa, the mother goddess in Chinese pantheon, as a punishment to King Zhou after he irreverently expressed his lust for the goddess as he viewed her statue in the temple. The obsession of the King for Daji is so pervasive that it leads to the decline of the dynasty [24].

In modern medical conception, treatment of *koro* can be challenging for physicians who are not aware of these cultural implications. Durst and Rosca-Rebaudengo [10] summarized the traditional remedies to the condition as:

1. preventive measures as prescribed by the culturally embedded folk beliefs. These take the form of popular superstitions, like warning never to walk in front of a tortoise because retraction of its head is a negative omen [25] or to pass near a water pond. Then there are the dietary taboos, such as refraining from eating too much *yin* food (e.g., bananas) and to avoid a certain legume called *kentJoer (Kaempferia galanga),* which means "retracts";
2. manipulatory strategies (pulling the penis outward, fastening of clamps and strings to the penis) performed by the patient himself, family members, or friends;
3. folk healing remedies, including special diets containing yang substances (e.g., bamboo, deer horn, red pepper jam, black pepper powder, ginger) [15, 25] and performance of rituals to chase away the evil spirit (striking gongs, setting off firecrackers).

Besides the evident differences with respect to modern medical practice, healthcare givers should benefit from understanding these considerations when managing *koro*. Stories like these are, in fact, common in Chinese traditional culture, and where folk beliefs still exert considerable influence, they are likely to be involved in the pathogenesis of this culture-related syndrome. The typical *suo-yang* victim has in fact been defined as a Han male (thus linking it to a socioculturally defined community), young, single, and poorly educated, who is afraid of *koro* and believes in supernatural powers. Furthermore, the age and education-related specifiers can

explain why most cases have occurred in male adolescents in rural China. Adolescence is a period of uncertainty, where the establishment of one's identity occurs along with (and partly resulting from) sexual maturation, a process that raises many questions and doubts. Due to the culturally driven, relative lack of open discussion about sexuality in China, it is not surprising that adolescents search for explanations and answers from the environment around them.

A recent study found that schoolteachers and mass media were identified as the two most important sources of sex knowledge in China [26], and data suggest that teachers and parents were often asked about less taboo and less sensitive topics such as puberty, but not about more taboo and more sensitive topics such as sexuality, sexual behaviors, and even sexually transmitted infections (STIs). Mass media and peers are often consulted in such cases, with the obvious risk of unreliable information [27]. For example, similar to many other countries, human immunodeficiency virus (HIV) infection has become an increasing threat to people's health in China [28], but lack of knowledge about HIV transmission and prevention among the general population is fairly common [29]. A large number of college students perceive themselves as having a limited knowledge of acquired immunodeficiency syndrome (AIDS) [30], and in an environment where most people remain uncomfortable providing sex education to adolescents, folk beliefs may still represent a common source of information, especially in less educated parts of China. This realization suggests the need to implement further research on sex education in China and its influence on common perceptions. The existing lack of clear data relating traditional cultural norms to sexual values and education among youth underscores the need for further attention to this issue, especially because it places sexually active Chinese youth at a greater risk for STI/HIV/AIDS [31]. In this context, healthcare providers need to understand the cultural barriers that place individuals at risk and, at the same time, promote awareness and education about sexuality.

6.3 Shen K'uei: The Role of Traditional Beliefs and Family Duty

China features the oldest sex literature in the world [12]. The exact moment when the Chinese began recording their sexual knowledge and practices is not known, but the Kangjiashimenji Petroglyphs, discovered in the late 1980s in Xinjiang region of Northwest China, are the earliest, and some of the most graphic, depictions of copulation in the world [32]. The oldest sex handbooks are also Chinese: *The Handbook of the Plain Girl* and *The Art of the Bedchamber*, both dated in the Later Han dynasty (from 25 to 220 AD), referred to a Yellow Emperor who was attempting to live a long, healthy life and obtain a form of immortality through sex. Another famous example is the *Jin Ping Mei* (The Plum in the Golden Vase or The Golden Lotus), a Chinese novel of late Ming dynasty (1368–1644). This work represents a milestone in Chinese fictional narrative as it is the first full-length novel to depict private lives of major characters and their "private desires" [33]. Not only does it feature the explicit description of sexual objects and coital techniques, but it also refers to acts

Fig. 6.3 Woman spying on male lovers, Qing-Dynasty, Chinese Sexual Culture Museum, Shanghai. From L. Crompton, *Homosexuality & Civilisation*, Cambridge/MA; London, 2003, p. 232. Source: Wikimedia Commons

of voyeurism, which are interestingly referred to as *pozhan,* a Chinese word which literally means "flaws, errors," that in the context of this novel assumes a completely new significance. Besides the frequent association of those acts with adulterous affairs, the transgressive aspect of "desire," as it stems from Chinese literature, may be understood by considering the strict dependence of such voyeuristic acts and closed spaces like bedrooms, gardens, shut gates, which represent an insight on people's private lives (Fig. 6.3). Similarly, closed settings are those found in the *bai meiren*, the illustrated books depicting the "Hundred beautiful persons" where *mei-ren* is a term used to identify iconic images of beautiful women in Han Chinese art, representing the ideal female beauty [34].

Although controversial, homosexuality (*tóngxìngliàn)* was also regarded a fairly normal facet of life and had been documented from ancient times. In the Chinese pantheon, *Tu'er Shen* (*The Leveret spirit*) or *Tu Shen* (*The Rabbit God*) is the deity of homosexual relationships.

According to a folk tale from seventeenth century, Fujian was a soldier who fell in love with a provincial official and decided to spy on him to see him naked. The official, having discovered the attempt, ordered that the soldier be tortured and killed, but after his death the soldier appeared in the form of a leveret (a rabbit in its first year) in the dream of a village elder. In that dream, the leveret asked local men to build a temple devoted to him where they could burn incense in the interest of "affairs of men" [35]. Even in *Dreams of the Red Chamber*, one of the China's Four Great Classical Novels, both same-sex and opposite sex acts are depicted. This apparently gay-friendly culture seems related to the fact that Confucianism did not "fault" homosexual relationships as long as they did not interfere with *family duty* [36].

This is a powerful concept even today in China, where love is frequently a responsibility charged with moral values. Familial relationships are built not only on affection but also on duty, which is respected from children toward parents,

from younger toward the elders, from wives toward husbands, and not so rarely vice versa [37]. Elders have the responsibility to raise the young until they marry, then it is the young's duty to take charge of the elders. The influence of family is deeply rooted in Confucian ethics and it is likely that, in traditional China, the burden of stigma of some psychological and psychosexual diseases falls on family rather than the individual. The disease of the individual becomes the illness of the family, and this has been presented as one of the greatest obstacles to providing optimal health care to the Chinese community [38]. The overpowering sense not only of the inability of the family to prevent the disease and take control over it, but also of the perception of the disease as a threat to the continuation of the family, especially as it interferes with the reproductive capacity of the individual, can play a role in sex-related issues. Nowadays in China, where homosexuality is no longer considered either a crime [36, 39] or a mental illness, disclosure can still evoke worry—especially for the family—as it deviates from the canons of the traditional, heterosexual family.

Marriage and procreation appear to be a primary concern in China and various picturesque descriptions are reported, from the most notable cases of the Shanghai Marriage Market where parents of unmarried adults gather in the park every Saturday and Sunday to "sell off" their children for marriage, to the ordinary setting in which parents consult a physician for their son's psychological complaint and obsess about their primary concern, asking "*Would the patient be able to get well enough to be married*?" "*Would his or her children have similar illnesses*?" [38].

Studies analyzing Chinese sex education picture books for children aged between 3 and 6 years also reveal a fundamentally stereotypical heterosexual image of sexuality and procreation, as moral tales that describe love of a man and woman often end with marriage and are rewarded by the birth of a "healthy, strong and clever" child [40]. The strong pressure of family to marry off their children in mainland China is likely to play a role in another culture-bound, sex-related, syndrome, the *shen k'uei,* which, according to some studies, is less likely to occur in married men, compared to unmarried [41]. Literally, the term means "kidney (*shen*) deficiency (*kuei*)," following the traditional belief that the kidney is the source of *Ching* (sperm), the essence of *Qi* (vital energy), which if conserved properly, shifts in the spinal cord to nourish the brain [42]. This understanding explains why, among the somatic symptoms perceived by the affected individual and attributed to the loss of sperm, forgetfulness, loss of attention, and weakness are commonly cited. The complex syndrome in which the individual suffers somatic symptoms with anxiety, believed to be caused by the loss of semen, has different names in different cultures, like *Dhat* syndrome (Indian subcontinent), *jinyian* (South East Asia), and *prameha* (Sri Lanka). The similarity among these conditions is that loss of sperm represents a loss a "vital energy," as "*Forty meals make a drop of blood, forty drops of blood make a drop of bone marrow, forty drops of bone marrow make a drop of semen*" (Veda 1500 BC, quoted in [43]). Nocturnal emissions and excessive masturbation are therefore seen as detrimental to men's health. This thinking had its parallel in the annals of the Western history of Medicine where the classification of masturbation as a disease, based on general suspicion that sexual activity was debilitating,

legitimized the conceptualization and application of drastic therapies, like infibulation or placing a ring in the prepuce to make masturbation painful [44].

In a report of 12 Chinese couples where male patients complained of ejaculatory incompetence, the common misbeliefs about loss of semen played a role and had to be addressed before proceeding with formal sex therapy [45]. Complaints of spermatorrhea, often accompanied by premature ejaculation, erectile dysfunction, and various psychological symptoms (guilt, panic attack, anorexia, etc.) can be viewed, as in *koro*, as a consequence of common misbeliefs stemming from Traditional Chinese culture.

The fear of loss of sperm, either through masturbation or sexual intercourse, again has roots in the Taoist doctrine and Yin-Yang, which considers the woman as an inexhaustible source of yin, while men have only a limited supply of yang [13]. As a result, sexual intercourse is a way for the man to nourish himself with yin essence, supposedly residing in the woman's vaginal secretions. Ejaculation was seen as the depletion of yang's energy, and losing semen without having taken enough yin energy could lead to serious health problems, according to this tradition [13]. Ancient Chinese *ars erotica* features plenty of teachings about how to prolong intercourse and bring women to orgasm several times without emitting semen; it further extolls the benefit of *retrograde ejaculation*, an ejaculatory disturbance where semen passes into the bladder rather than being ejected through the penile meatus (the presence of sperm in post-orgasmic urine confirms this diagnosis [46]). "Concealed" ejaculation, as a form of self-restraint based on cultural beliefs, should therefore be added to the already acknowledged causes of retarded ejaculation that include [47]:

1. Functional/anatomical disorders of the bladder neck anatomy, such as impaired sphincter bladder relaxation.
2. Autonomic neuropathies, with inadequate bladder neck closure. Retrograde ejaculation and anejaculation are frequent complications of diabetes mellitus, mostly due to the presence of associated diabetic autonomic neuropathy [48].
3. Iatrogenic causes such as drugs and surgical procedures, including medical treatment of LUTS/BPH with alpha-blockers, especially with tamsulosin and silodosin; or invasive BPH procedures, such as transurethral resection of prostate (TURP) [49, 50].

Retrograde ejaculation seems in fact similar to the Bangladeshi syndrome described among otherwise healthy men living in the East End of London, complaining of urethral discharge and penile pain, but with no evidence of sexually transmitted disease [41]. These men frequently insisted that sperm was being lost in their urine, although this was actually occurring due to prostatovesicular overflow, a physiological consequence of sexual continence.

A study from the National Taiwan University Hospital in 1977 on 87 male patients visiting the special clinic for sexual problems identified 64 patients belonging to the sexual dysfunction group, specifically 32 with secondary impotence, 31 with premature ejaculation, and one with delayed ejaculation, while the remaining

23 had sexual neurosis and *shen k'uei* as the primary problem [41]. The 23 patients with *shen k'uei* did not claim any sexual dysfunction but rather complained of anxiety associated with unsuccessful attempts to stop masturbation and sexual emissions. Those 64 men who did not have *shen K'uei* and did not believe in it were married and of higher socioeconomical status, affirming that culture-bound syndromes are more common among patients of lower socioeconomic class due to their strong adherence to folk beliefs. However, 52 out of 64 also attributed their symptoms to frequent masturbation, nocturnal emission, or frequent intercourse, revealing that even among educated Chinese, traditional attitudes endure. For all 87 patients, treatment was "complicated," due to the men's strong perception of having a physical disorder, prompting a urological workup (renal analysis, sperm analysis, and pelvic plexus test) before being able to begin formal sex therapy.

Thus, although China has embraced a Western medical perspective for nearly a 100 years, traditional approaches still exert influence on Chinese medicine, especially regarding the unwillingness to differentiate between psychological and more organic functions [51, 52]. The channeling of psychological affective states into somatically experienced conditions is evident by the manner in which some common dysphoric states are expressed in the Chinese language, *shen kuei*, namely "kidney deficiency," being among them. Although a detailed analysis of this somaticization is beyond the scope of this chapter, such somaticizing might impact care-seeking among Chinese patients, especially in rural areas where cultural tradition is still strongly influential. For example, for a sexual disorder these individuals may choose to consult a general practitioner or a traditional healer, as they experience their disease as a physical (somaticized) one, expecting a somatic rather than psychological intervention. Furthermore, the fact that some Western medical treatments include adverse effects may dissuade patients from continuing treatment due to the *nocebo* effect [53].

6.4 *Liumangzui*: Love in Modern China

The importance of family has been stressed in previous paragraphs, and its influence on sex-related anxiety has been clarified, as procreation is viewed as an undeniable duty for Chinese people. Although this tradition is tied to the Confucian view, the family aspect has not been analyzed from the perspective of social norms. An overlap between traditional culture and the social norm spheres appears to exist (Fig. 6.1), especially after the 1949 reforms in China that led family systems to embody a more "political" aspect, becoming a community that reflected the needs of the State [36]. In the new socialist State where the function of family had to be reconstituted, the "creation of normative standards of sexual conduct" occurred, such as the Marriage Law of 1950 [54]. Not only was the new law seen as a cornerstone upon which the new socialist family could be reconstructed, but also as a means to regulate both gender and sexuality, mostly through heterosexual monogamy. However, by the 1980s "sexual expression was viewed with contempt and as the least important activity of life," and policies of sexual conservatism were

reinforced [13]. For example, "*Hooliganism,*" as a disruptive or unlawful vandalic behavior, was an umbrella term that covered a broad variety of behaviors that offended against public order, being a form of crime committed in order to "gain pleasure" [39]. The offense of hooliganism (*liumangzui*) was not formally defined until the promulgation of the Criminal Law of the People's Republic of China in 1979. During that time, for the benefit of "public order," various sexual behaviors were also condemned by Article 160 of Criminal Law. Prostitution, producing or selling pornography, and bigamy, although all largely present in the traditional Chinese culture, were all explicitly forbidden. Interestingly, other types of behaviors not specifically prohibited by law were still regarded as questionable: premarital sex, adultery, sexual relations with multiple partners, group sex, and events like "hooligan dance parties" and "lights off parties" [36, 39]. In theory, homosexuality was also illicit, although there was no general consensus among scholars regarding the effective legal punishment for homosexual behaviors [55, 56]. In practice, the line between bothering and criminal (sexual) behaviors was very difficult to draw.

Hooliganism was removed in 1997 from Criminal Law, but the concept of *liumangzui* still exerts considerable power in China [39], both on the traditional and the social aspects, here reviewed.

Considering the ancient folk tales that still raise considerable appeal in Chinese theater, movies, and books, it is interesting that the characterization of feelings between men and women is mostly seen on the spiritual level, as there are no descriptions of physical contacts, with even the simplest gestures of affection such as holding a hand being very rare [13, 57, 58].

A typical example is the love story between the *Cowherd* and the *Weaver girl*, who was a goddess. The legend is famous in China ever since the Han Dynasty, as it gave origin to the *Qixi Festival*, also known as *Chinese Valentine's day*. The tale is a love story between Zhinü (the weaver girl) and Niulang (the cowherd). Their love was not allowed, and so they were punished by divinity and separated by the Tianhe, the Milky Way. The legend says that only 1 day per year, on the seventh day of the seventh lunar month, can the lovers reunite. The story, which symbolizes the power of love and holds importance for newlywed couples, does not feature any physical contact, although their children are also mentioned. Most of the story is focused on the description of feelings, indeed ignoring the physical expression of such feelings.

Another example is *The Legend of White Snake*, also known as *Madame White Snake*, presented in several major Chinese operas, films, and television series and now counted as one of the China's Four Great Folktales [59]. The tale is a love story between a human and a white snake: when the white snake was small, it injured itself, but a man cared for and healed it. After many years, the white snake became very powerful and was able to transform into a woman, aiming to find the man who helped her many years before (interestingly, the Western, Freudian perception of the snake as a phallic symbol or a devil—as in the Bible—is overturned here). They met, fell in love, married, and had children; and their love overcame difficulties—as a monk had discovered that she was not a common person and wanted to capture

her. But again, as with the story of the Weaver and the Cowherd, there is no description of physical contact.

There is also the example of *Liang Xiaobo* and *Zhu Yingye*, the Chinese "Romeo and Juliet." These classmates had a very complicated love story, but in the end, they died for their love, became two butterflies, and continued their love for one another. The emphasis is on the intense and durable feelings between them, and again, all sexual descriptions are indirect.

Given such lore, it seems reasonable to conclude that, despite the change in attitudes that accompanied the Open Door Policy [1, 60], considerable influence is yet exerted by the paradigms that have dictated social norms for years (*liumangzui*), including the powerful concept of traditional family duty.

Although the prevalence of commercial sex has more than doubled since 1984 [61] and the factory of pornography is steadily flourishing, studies reveal that issues like premarital sex, extramarital sex, and sex work are still perceived with some disinclination at least in some parts of China. Adequate attention to these cultural attitudes should be given by healthcare practitioners when dealing with sex-related issues in China, as a straightforward approach to the topic might interfere with the patient relationship.

6.5 Wen-Wu Dyad: Masculinity in Modern Chinese Society

The need for a separate in-depth discussion of Chinese masculinity is motivated by two assumptions that emerge from gender studies [62]. The first is the paradigm of *yin-yang*, already introduced, that emphasizes the union and the "fluidity" between the two sexes but does not adequately shed light on "maleness" nor explain the imbalance in power between the sexes that characterizes the Chinese society [63]. The second is that the contemporary concept of the Chinese sexual *soul* seems differently constructed from that of the West, a point that is particularly evident when considering the concept of masculinity.

The Chinese paradigm that offers a better analysis of masculinity is the binary opposition between *wen (*文), the cultural or civil, and, *wu (*武), the physical or martial. This dyad encompasses social principles fundamental to both social thought and state generation. The *Wen*, which literally means "peaceful; serene; to calm," represents the idea of harmony, the union between nature and form, namely the "cultural nature": the way of Wen (*Wen dao*) is thus the way of establishing peace through literary education [64]. Conversely, the *Wu* represents the force, the military power, the punishments. In the "Art of War," the oldest strategic treatise in the world, Sun Tzu reminds the reader that both principles are required for the good commander: "*gù lìng zhī yǐ wén; qí zhī yǐ wǔ.*" Literally, "therefore, in commanding them (soldiers), use civility (*wen)*; to submit them use martial discipline (*wu)*" [65]. Therefore, a good commander embodies both military and administrative skills. The traditional unit of *wen-wu* is related in the examples of famous Chinese military heroes, such as Guan Yu.

Guan Yu was a general serving under the warlord Liu Bei during the Eastern Han Dynasty of China (around 200 B.C). He played a significant role in the events leading up to the end of the Han dynasty and the establishment of Liu Bei's state of Shu Han during the Three Kingdoms Period. His achievements were so glorified that he was deified as the "Emperor Guan" after his death and became famous through generations of storytelling, culminating in the fourteenth century historical novel "Romance of the Three Kingdoms." His fame continues to the present, and he is not only widely worshipped across China, but in popular East Asian culture he also stands as a model of loyalty and righteousness.

According to scholars, despite the origins of the *wen-wu* concept and the Guan Yu myth in ancient imperial culture, their influence continues to shape masculine identity even today [66]. That is, masculinity is reflected more as a cultural product than as a biological essence, with changes in ideal masculine beauty over the dynasties related to the fluctuating importance of physical activities [13]. Men of the Tang period cultivated a virile, martial appearance, having thick beards, whiskers, and long moustaches, and admired bodily strength. Under the Manchu era, the martial arts were monopolized by outside conquerors, and the Han reaction was to abandon what they considered a barbarian and vulgar ideal of beauty and to shift toward a more delicate "cerebral" version, "with pale face and narrow shoulders, (with the man) passing the greater part of his time dreaming among his books and flowers" [13].

The same perspective is borne out from early descriptions that the Chinese made about Western men, as having four testicles and an excess of body hair [67]. Both characteristics imply a highly sexualized view of Western males, not necessarily as truly masculine in the Chinese sense, but rather as very male in an "animalized" sense, clearly a pejorative description. This oversexualization of "the other" evokes similar ideas expressed through Victorian-era portraits of colonized peoples, or, in the 1960s of black people, as being highly sexed.

In fact, although the *wen-wu* dyad ideally represented male essence/beauty, studies now reveal that *wen* was traditionally preferred over *wu* in the past, as it was more aligned with the Confucian canon of social and family obligations [63]. Being a good, well-educated, student is *wen*. Achieving a good job position is *wen*. Honoring family and traditions is a sign of commitment to *wen*.

Nowadays, with the process of globalization and Western influence, Chinese males are exposed to other models of masculinity. Perhaps in the attempt to dismantle the stereotypes that characterize Eastern males, a train of contemporary movies, novels, and television shows have partially shifted the paradigm of Chinese masculinity toward a more *wu* figure [62]. Kung fu movie characters such as Bruce Lee, Jackie Chan, and Jet Li may reflect this trend. Nevertheless, oversimplification of Asian stereotypes warns against certain assumptions. First, the application of the "macho man" stereotype, well known in Western tradition, is largely inappropriate to the Chinese case, because no such concept exists in traditional Chinese culture.

Second, the *wu* man may erroneously be viewed as the sexualized counterpart to the "cerebral" *wen*. Rather, the "sexual" in Chinese is probably best realized by the combining of the complex perspectives drawn from both traditional culture and social norms. In light of these considerations and at the risk of sounding presumptuous, we might identify the "*Guan Yu complex*" as a defining paradigm of Chinese masculinity, one that encompasses both the sophisticated overlap of societal and familiar values and considers the impact of confrontation with the Western model.

Given the relationship between sexual dysfunction and psychological distress, also evident in the Chinese population [68], such a model could better situate patients in their cultural milieu, rather than viewing them simply as a biological entity. The currently flourishing field of andrology in China could take the lead on this (andrology units are present in many prestigious hospitals and universities in China, and the andrology journal with the highest impact factor in the world—the Asian Journal of Andrology—is based in Shanghai) by assuming a systems approach to sexual medicine that attends to the couple (patient and partner) for both research interest and management of the sexual problem [69]. The heavy focus on men's sexuality in China—to the exclusion of women's and couple's problems—deserves rethinking. A broader approach to sexual problems in China is tenable for two reasons. The first is the well-recognized Chinese capacity for integrating tradition and innovation, as seen in many areas of Chinese development over the past several decades. Equally important, a holistic approach characterizes traditional Chinese culture as well as Traditional Chinese Medicine. This "systems" perspective could drive contemporary sexological practice in China (considering male, female, couple, family, society, economy, politics, environment, culture, etc.) as domains for exploration when dealing with human sexual and reproductive health [52].

6.6 Conclusion

Sexuality entails the way people experience and express themselves as sexual actors. Being shaped by mythological, religious, moral, social, ethical, and cultural aspects, sexuality could thus be broadly defined as one salient manifestation of a society, and differences in sexual behaviors among cultures can be fully understood only in the context of the aforementioned aspects. In China, as well as many cultures undergoing rapid change, sexuality is yet a controversial topic that is adequately explained by neither traditional paradigms nor Western, post-modern archetypes. Nevertheless, no single contemporary society seems better positioned to understand these disparities, and to prepare for the future by fusing the ancient and the modern to create the modern *sexuality of the Dragon*, a metaphor for the melding of the beauty and power of sexuality.

Box 6.1 Key Points

- Research needs to better integrate the biological and cultural aspects of sexuality in China. Understanding the complex overlap of traditional beliefs with social norms can help the health practitioner **avoid oversemplification** regarding sex-related issues.
- Underlying concepts such as *yin-yang*, *wen-wu*, and *liumangzui* help position sexuality within a **culture-oriented approach**, especially regarding culture-bound syndromes.
- Regarding STIs and HIV, **sex education** in China needs to be improved.
- The concept of **masculinity** in China does not necessarily conform to Western models and therefore represents an area requiring both sensitivity and caution when raised with respect to sexuality, sexual identity, and sexual performance.

Box 6.2 Glossary of Selected Terms

Chinese name (pinyin)	English translation	Simplified Chinese characters
Huángdì Nèijīng	The Inner Canon of the Yellow Emperor	黄帝内经
húli jīng	Fox spirits	狐狸精
Jīng	Essence (spiritual energy residing in the kidneys, associated with sexual activity)	精
koro	Genital retraction syndrome	
liúmángzuì	The crime of hooliganism	流氓罪
Qi	Vital energy	气
pòzhàn	Flaws, errors (used to refer to voyeuristic acts in ancient Chinese erotic novels)	破绽
shènkuī	Kidney insufficiency or weakness	肾亏
suo-yáng	Shrinkage of penis	缩阳
tóngxìngliàn	Homosexuality (literally, same-sex relations/love)	‘同性戀
wen-wu	Cultural (or civil) and physical(or martial)	文 武
yīnyáng	Female/male—Night/day—Positive/negative, etc. (opponent forces in Taoism)	陰陽 or 阴阳

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Sexual Fluidity Behind Culture

7

Shadeen Francis

7.1 An Introduction to Sexual Identity

Medicine is one of the many fields tasked with reaching beyond the confines of scientific knowledge to demonstrate an ability to access humanistic, person-centered care. Transitioning away from the narrative of the omnipotent provider having absolute expertise, training programs and healthcare organizations are privileging the perspective of patients in their searches for health and healing. This change has necessitated a commitment to developing practitioners' cultural competence, social intelligence, and awareness of self in order to adequately address patient concerns [1]. In this transition, many previously ignored aspects of the human condition are increasingly recognized as not only beneficial, but also necessary to positive health outcomes. Beyond traditional markers of age, sex, and medical history, social identities such as nationality, socioeconomic status, and sexuality are now seen to be relevant to a person's health status and prognoses. Therefore, it is integral to consider the diversity of human identity in order to better understand patient concerns, disrupt the development of preventable health episodes, ameliorate barriers to the patient–provider relationship, design effective interventions, and improve health outcomes. As part of this global shift in awareness of patient identity, the field of sexual medicine is strongly encouraged—as appropriate—to include an exploration of patients' sexual identity within the scope of routine clinical assessments [1, 2].

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Sexual identity refers to an individual's understanding of themselves as a sexual being[1] [3]. Personal understanding can be nuanced and complex, taking into account various aspects of self. Sexual identity involves several overlapping dimensions:

- *Sexual orientation*: an identity marker designated by whom a person is attracted to [3],
- *Sexual behavior*: the forms of expression that display aspects of one's sexuality, such as how a person may dress or whom they may partner with [3],
- *Sexual fantasy*: the internal representations of desire that may or may not be acted upon [3], and
- *Accompanying sexual feelings*, such as excitement, shame, disgust, and satisfaction.

Sexual identity can also be related to one's *gender identity* (how one sees or does not see themselves in relationship to masculinity and femininity) [3], or their *biological sex* (the label or "assignment" given to individuals at birth in response to external genitalia, internal organs, and sex-related hormones). It is reliant on self-awareness, and is directly influenced by a person's social and cultural context. As such, sexual identity is subject to changes and fluctuations as a person's context changes. For example, changes in age, lived experience, or social group may result in shifts in how a person identifies sexually.

Specific changes in the components of sexual identity are referred to as *sexual fluidity*. This chapter focuses on understanding such changes and fluctuations to better equip healthcare providers and those generally interested in the fields of andrology and sexual medicine to address sexually fluid persons with compassion and competence.

7.2 Understanding Sexual Fluidity

7.2.1 Defining Sexual Fluidity

A person's sexual identity can change not only during puberty, but also across the lifespan [4]. Sexual fluidity, broadly, concerns changes to one or more aspects of sexuality. There is yet to be a universally accepted definition for the term, but sexual fluidity generally describes changes to one's sexual identity as a result of shifts in the domain of sexual attraction [3]. Fluctuations in sexual attraction are representative of sexual fluidity.

In understanding the foundational elements of sexual identity, sexual fluidity can also be better understood. The most central elements to this understanding are sexual attraction and sexual orientation.

[1] Gender-neutral terminology (they, them, their, etc.), although at odds with traditional grammatical convention, is preferred in the LBG literature to gender specific terms such as he, she, him, her, himself, herself, etc.

7.2.2 Differentiating Attraction and Orientation

Although interrelated, the dimensions of sexual identity can operate independently of one another. One's sexual expression may or may not be tied closely to their gender. A person's fantasies are not necessarily represented by their orientation. A person's behavior may not be reflective of their sexual identity. Sexual fluidity does not necessitate a lasting relationship of a certain kind; people may simply acknowledge the attraction without action, or engage in casual or non-committal contact [5]. For example, not only have the vast majority of lesbians had heterosexual experiences, but as many as 46% continue occasional sexual encounters with men while openly identifying as a lesbian [6]. These experiences can involve a wide range of complexity. Consider this scenario:

> An individual may initially recognize the desire to have sexual relationships typically with women, but come to find themselves attracted to people of all genders, and feel most drawn to people with androgynous forms of gender expression. Many years later, the same individual may find that their sexual or romantic attractions have again changed –perhaps in response to any number of factors, including living in a different environment, exposure to different communities, new levels of personal or spiritual understanding, a formative sexual or romantic experience, personal choice, some combination of all of these factors, or for a different reason altogether [7].

As in sexual identity, the terms attraction and orientation operate independently as well, demonstrating overlap rather than being synonymous. Orientation and attraction are often used in the literature as interchangeable; however, there are meaningful differences that become relevant in the context of sexual fluidity. *Sexual attraction* is the experience of arousal or chemistry that a person may consciously or unconsciously feel [3]. Sexual attraction is not limited to the feelings one may have for a person, but can extend to places, situations, or objects. Conscious signs of attraction may present in the form of flirtation or acknowledged desire to affiliate with the subject of interest. Some signals of attraction are implied through physiological responses to the subject, such as increased heart rate, pupil dilation, or genital swelling [8, 9]. Shifts in attraction are more common than shifts in other aspects of sexual identity or partner gender [10]. Despite the presumed fixed nature of sexuality overall, the expression of a person's full spectrum of attraction can unfold in response to experiential or developmental inputs, in the same way that certain physiological characteristics may not be expressed without the right environmental influences [11].

Understandings of sexual fluidity have been limited by the overreliance on treating sexual orientation as a universally stable trait [12]. It has been argued that the study of human sexuality has tended to be retrospective and cross-sectional, ignoring the depth of the construct [12, 13]. *Sexual orientation* is a multidimensional construct that relates to three primary dimensions: attractions, the sex of sexual partners, and orientation identity [3]. Orientation is frequently described as the nature of one's sexual attraction to women, men, neither, or both [14]. Therefore, orientation and attraction are not the same; attraction is a component of a larger landscape of orientation. As such, it can interact, moderate, or have little to no bearing on the other elements of sexual orientation.

Because identities are self-defined and subjective, there are any number of ways someone might describe their orientation. Within a person's recognition of to whom they are emotionally, romantically, or sexually attracted is also the possibility for this attraction to be expansive, inclusive, and nuanced. For example, a person may or may not make a distinction between their orientation to sex and to romance, that is to say that the way they see themselves sexually may also be reflective of who and how they love. Scientific discourse holds that orientation determines the gender of a person's sexual interest and romantic partnership; however, it is also true that at least in some cultures romantic bonds can then inform sexual interest without interacting with orientation at all [15]. It is also possible for people to fall in love with people they are not sexually attracted to. Rather than being all-or-nothing, sexual desire and romantic attraction can operate independently of one another and may interact to shape behavior, orientation, or both. As such, people may identify with more than one orientation at a time, such as being gay (homosexual) and demisexual. Even in the case of arranged relationships, a romantic connection or attraction can build at a different pace than the sexual connection.

At best, there is a commonly understood vernacular for the terms someone uses to identify themselves. However, new, more precise language is constantly being constructed to reflect the subjectivity of human relationships and attractions, as indicated in Tables 7.1 and 7.2.

Table 7.1 A non-exhaustive list of sexual orientations

Sexual orientation	Description
Abrosexuality	Sexual identity that changes or fluctuates frequently
Androgynosexuality	Sexual attraction to androgynous people
Androsexuality	Sexual attraction to masculinity, irrespective of sex or gender identity
Asexuality	Sexual attraction that is rare, infrequent, or generally non-existence to no sexual attraction to anyone
Bisexuality	Sexual attraction to two genders
Ceterosexuality	Sexual attraction only to non-binary people (typically used by those who identify as non-binary themselves)
Demisexuality	Sexual attraction that only forms after establishing an emotional connection
Gynosexuality	Sexual attraction to femininity, irrespective of sex or gender identity
Heterosexuality	Sexual attraction to people of the opposite sex
Homosexuality	Sexual attraction to people of one's own sex or gender
Omnisexuality	Sexual attraction to all genders, usually without hierarchy of preference
Pansexuality	Sexual attraction that is not concerned with gender; attraction to persons regardless of gender
Pomosexuality	Identity category for people that eschew or do not well fit into other orientations
Polysexuality	Sexual attraction to many or some, but not all, genders
Queer	An umbrella term referring to anyone rejecting the confines of sexuality and gender binaries
Questioning	A label for those re-examining their sexual orientation
Sapiosexuality	Sexual attraction in response to a person's intelligence more than their gender

Table 7.2 A non-exhaustive list of romantic orientations

Romantic orientation	Description
Aromantic	Romantic attraction that is non-existent; an aromantic person may not desire romantic relationships
Biromantic	Romantic attraction to two sexes or genders
Demiromantic	Romantic attraction that only develops after establishing emotional connection
Gray-romantic	Romantic attraction that is rare or infrequent
Heteroromantic	Romantic attraction to a person of the opposite sex
Homoromantic	Romantic attraction to a person of the same sex or gender
Panromantic	Romantic attraction to all genders

In the case of sexual fluidity, as attraction shifts, people may still identify with the same orientation. Thus, a person's attractions may change without impacting their described orientation or sexual identity. One hypothesis for this phenomenon is that many people whose attractions shift already maintain nonpolar sexual identities, which prevents cognitive dissonance should attractions come to fall outside what is expected or clearly described by their sexual identities. In other words, people who are sexually fluid may identify outside the binary categories of heterosexual and same-sex loving, identifying in ways that are supportive or nonconflictive with attraction changes [15]. Others may also adopt new labels or language to reflect a new emergent identity.

7.2.3 Distinction from Bisexuality and Erotic Plasticity

Sexual fluidity is not the same as bisexuality, and cannot be reduced to simply being confused, changing one's mind, or being indiscriminate. A person who identifies as bisexual acknowledges attraction to more than one gender, often referring specifically to being attracted to both men and women (however, this is not an exclusive definition of bisexuality) [5]. A bisexual person's attractions can be consistent and enduring in the same ways as other sexualities. These individuals may *also* consider themselves sexually fluid if their degree of attraction to genders changes. Therefore, in the same way that a person who identifies as heterosexual might recognize that they move into or out of same-gender attraction, a bisexual person may be primarily (but not exclusively) attracted to a particular gender and may over time come to be attracted to another gender or genders [16].

As is true of bisexuality, sexual fluidity is not to be equated with choosing a sexuality. The flexibility seen is not an implication of conscious choice. On the contrary, sexual fluidity often operates in a covert manner, wherein individuals who had no prior same-sex attraction can suddenly be attracted to a person of the same sex [2, 16]. This can be general or tied to meeting a particular person to whom they develop a specific attraction. Despite the experiential nature of person-specific attractions, because they are not occurring by choice, they cannot be forced or "corrected." Another reason that bisexuality cannot be equated to sexual fluidity is that to

self-identify as bisexual would mean that a person has achieved a stable sexual identity [16]. Sexual fluidity represents instability; a mutable and changing experience.

Sexual fluidity is commonly conflated with erotic plasticity; however, these terms have different meanings. Fluid sexuality suggests responsiveness to a variety of genders, although not necessarily at the same point in time. Erotic plasticity avoids focusing on changes to attraction or to identity. Instead, erotic plasticity involves changes in the desired frequency of sexual activity and shifts in the preferred characteristics of partners [17].

7.2.4 Research Origins of Sexual Fluidity

The premise that sexuality and sexual attraction may not be static was first presented in research done by biologist Alfred Kinsey in 1948 and 1953 [18, 19]. In his influential works on American sexuality, Kinsey interviewed thousands of participants on their attractions and sexual behavior. What became clear in the responses was that many people did not fit into distinct categories of sexuality; there were identities between homosexual and heterosexual. As hundreds of American subjects were interviewed, it was not unusual for their reports to include sexual experiences and fantasies across genders, regardless of orientation or relationships status. This led Kinsey to believe that sexuality is subject to change over time [18]. However, in his belief, the mobility of orientation moved from one direction to another, stabilizing at some point in the journey. Changes in attraction were linear, moving exclusively towards homosexuality or heterosexuality.

The research on non-linear variability deepened with the work of psychologist Lisa M. Diamond, who explored sexual identities of heterosexual, bisexual, and lesbian women. The term sexual fluidity is attributed to Diamond's investigation into female sexuality. In her seminal text, *Sexual Fluidity: Understanding Women's Love and Desire,* she argued that there is possibility for significant fluidity in sexual attraction over the life course, as evidenced by sexual behavior and self-reported attraction [16]. In following 100 non-heterosexual women over a period of 10 years, she came to recognize that the existing language about sexuality was not representative of the versatility and diversity of experiences. She offered sexual fluidity as a key to "an expanded understanding of same-sex sexuality" [16]. Diamond posited that by acknowledging sexual fluidity as a biological fact, we should ultimately reconceptualize sexuality as existing beyond binaries.

7.2.5 Gender Differences

According to the literature, women may have an inherently more fluid sexuality than men. Women are more likely to report orientation and attraction changes than men, showing more variability in their identities over a 5- to 10-year period [20]. Within her research, Diamond defined sexual fluidity specifically along the lines of

gender, describing it as the "flexibility in women's sexual responsiveness...that makes it possible for some women to experience desires for either men or women under certain circumstances, regardless of their overall sexual orientation" [16]. Diamond argues that women's sexuality is fundamentally fluid and with that, has a greater degree of situation dependency than other genders.

Physiological evidence has demonstrated women's greater tendency towards sexual fluidity. The sexual arousal patterns of women show that in comparison to men, women's arousal was not significantly tied to their orientation, specifically, that their genital arousal was not higher for members of the sex they were sexually oriented to [8]. In one study, women responded with equal levels of arousal to both heterosexual and lesbian erotica, regardless of their orientation or their self-described attractions. Women also showed orientation-independent responses through other arousal signals, including pupil dilation in response to erotic stimuli [9]. Men, however, showed arousal responses that demonstrated their reported attractions and orientation, only demonstrating physiological arousal to the erotica that aligned with their orientation. These findings suggest a decoupling of arousal, partner gender, and orientation for women. When explored further, women consistently maintained that their sexual orientation was less tied to gender than to characteristics of the person or relationship [21]. This was especially true for women who identified as bisexual or as lesbians [21]. The literature has not demonstrated a parallel in the experience of straight or gay men; however, monogamous bisexual men do show more fluidity than their heterosexual or gay counterparts [4, 15, 22].

Fluidity is also evident in self-report data. In the USA, adult women are more than twice as likely to have had same-sex attractions and experiences as compared to men, irrespective of their orientations at the time of the attraction or the survey [23]. Women are more likely to have identified with more than one sexual orientation in their lifespan and are also more likely to report non-exclusive orientations (such as being bisexual or unsure of their sexuality) than males, who more commonly describe themselves with more polarity, describing themselves as being exclusively gay or heterosexual [16, 17, 24]. In a study of college-aged women who described themselves as lesbian or bisexual, 25% moved away from those identities [25]. Half of that group came to refer to themselves as heterosexual, with the rest moving away from the use of labels at all [17, 25]. Despite the changes, none of the women described their initial identities of lesbian or bisexual as "a phase," and all were open to the possibility that their orientation and attractions may change again in the future [25]. These findings add to a growing body of research that recognizes women's sexual identity as malleable, situation-dependent, and responsive to both conscious and unconscious drives through the pathway of fluidity.

7.2.6 Sexual Fluidity Across the Lifespan

While data around sexual fluidity is consistent in various age cohorts of adults, these effects may not be present in adolescence, as studies have had difficulty replicating the presence of a gender difference in sexual fluidity over time. Or, the direction of

the difference directly opposes that which is seen in adulthood. To illustrate, in a longitudinal study conducted on adolescents aged 14–21 years, women were 3.6 to 5 times more likely to maintain their same-sex attractions than men, consistently identifying as lesbian or bisexual over a 1-year period [26]. Findings such as these could mean that sexual fluidity is not as reliably present in emergent adulthood for non-straight youth, or that the time span of these studies may not be long enough to reliably notice shifts in attraction or orientation identity for adolescents.

Adolescence is an important period for sexual orientation development [26]. Fluidity during adolescence may not reflect absolute changes in sexual orientation but rather be representative of the overall process of identity development [27]. Studies of youth largely indicate that differences are seen less in the category of gender and more on orientation-based subgroup differences (i.e., lesbian, gay, heterosexual, etc.) in fluidity [28]. Youth that identified as non-heterosexual were more likely to change orientation or report different attractions than their heterosexual counterparts, regardless of gender, over a 6-year period [28]. Youth were more likely than adults to identify with non-exclusive identities (e.g., "mostly heterosexual"), and this subgroup showed less consistent orientations compared to their gay and lesbian peers, affirming that orientation may play a more significant role than gender in adolescence [28].

7.2.7 Notes on the Applicability of Research on Sexual Fluidity

There is currently a dearth of data on trans, non-binary, and gender non-conforming individuals. Research including a wider gender sampling would help us explore whether gender identity and gender roles may be implicated in the development of sexual identity.

Sexual fluidity is but one way of being and may well not represent the majority of experiences. In a longitudinal study of American adults, sexual orientation identity remained largely stable over the six-year period, suggesting that while fluidity is possible, stability of orientation and sexual identity is more common than change [20].

7.3 Perspectives of Sexual Fluidity

7.3.1 Evolutionary Perspective

Evolutionary psychologists' view of human behavior is that maintained features and behaviors at one point in evolutionary history must have conferred survival benefit. One such explanation of sexual fluidity is that it increased women's ancestral reproductive success by mitigating the risk of paternal disengagement through the process of allomothering. Allomothering is the condition when women partner with unrelated women to garner parental investment from a same-sex partner in the absence of a reliable male partner [29]. This strategy would have provided benefit to

the sexually fluid woman by ensuring adequate care for her offspring in the event that males were unavailable due to injury, death, absent on extended hunts, preoccupied with fighting, or pursuing other mates. These same-sex partnerships would be placeholders for paternal engagement. Ensuring another woman's investment would have increased the chances that her offspring, and therefore her genes, would survive. Therefore, allomothering creates context for sexual fluidity as a reproductive strategy.

Some researchers, including Diamond, maintain that sexual fluidity in women is not a contingent adaptation, but a byproduct of other evolutionary developments, specifically the decoupling of arousability (the dynamic capacity to be aroused) and proceptivity (a female's libido or willingness to have sex for reproduction) [30]. This separation occurred when "higher primates" evolved beyond having observable signs of fertility and sexual interest [30]. From this perspective, the explanation for the emergence of fluidity allowed those who would never otherwise pursue such a partnership to be motivated towards same-sex unions. This was not seen as conferring evolutionary benefit through the passing of genes, but rather as a social gain [30].

7.3.2 The Essentialist Perspective

Essentialism originates from a school of philosophy that believes all things have a set of characteristics which make them what they are. As it relates to sexuality, the essentialist view posits that identity is ultimately fixed [20]. Behavior may fluctuate, but there is a prevailing "truth" that is not rooted in subjectivity, but in a biological design. The search for a "gay gene," a specific genetic marker to explain same-sex attraction through biology, is an example of an essentialist position. Some lesbian and gay communities have used this narrative to try to combat homophobia and heterosexism; by asserting that identity is immutable (and therefore cannot be changed through violence, religion, or choice), they seek to access identity legitimacy, increase their safety, and be seen as worthy for social and political inclusion [7].

While it can be understood that some aspects of self are innate, that people really are "born this way," to assume that every aspect of identity is fixed would be to deny the influence of environment and context on identity [7]. Attraction can develop in response to a bond developed with a particular individual [3, 10]. It also does not take into account that a person may come to better understand or differently express their core or innate attractions over time and thus come into attractions that were not present at earlier stages. Orientation is a complex interplay of hormonal, genetic, cultural, and social influences [11]. A number of factors can impact orientation, including partner availability, hormones, family history, transformative relationships, cultural norms, feelings, beliefs, and self-awareness. It is unsurprising then that even a largely static category can have room for changeability.

Remembering that attraction itself is different than behavior, identity may shift purely along the axis of sexual expression, but not impact orientation. In such cases, orientation remains stable across the lifespan despite fluctuations in other aspects of identity such as attraction. Scenarios like these are not well accounted for in the

essentialist perspective, apart from the denial or dismissal of the authenticity of the shift. Some perspectives attempt to bridge this gap by distinguishing between sexual orientation as an innate attraction, and sexual orientation as an identity in itself [31]. Organizations like the American Psychological Association (APA) posit that sexual orientation is biological and therefore continuous, whereas sexual orientation identity may change at any point in a person's life [31].

7.3.3 Social Constructivist Perspective

The social constructivist view posits that sexuality is a product of cultural and psychosocial processes [32]. According to this view, men and women are not socialized in the same ways, and differences in socialization explain the differences in the stability of sexual attraction.

Men in the Western world tend to be socialized around masculine tropes. In the case of sexuality, this leads to sexual narratives centering physical factors as the primary criteria for desire, such as attractiveness, whereas women's sexuality is groomed to organize around sociocultural factors, making women's attractions and desires more receptive to change in response to environmental and emotional context [17]. Women are socialized to experience emotional intimacy and sexuality as interrelated or interchangeable experiences [12, 33]. The result is that women's sexual desires are especially sensitive to situational and interpersonal factors, making it possible for her to develop sexual desires and to enjoy sexual contact in ways that run counter to her orientation. In addition to the bonds formed with their partners, women are also expected to form close emotional bonds with friends and colleagues; relationships and emotionality are intended to be more salient for women than men.

Men are not fully excluded from the pressure to attend to interpersonal dynamics in their awareness and expression of sexual attraction. While less context-driven and a smaller response, men are socialized to consider their relationship orientation as important to desire, showing different attraction responses to when they are in periods of relationship pursuit (looking for a partner, non-exclusively dating) and when they are not looking for new partners [34]. The expectation is for men to report experiencing less attraction to non-partners while in a relationship, and this is reflected in their responses [34]. This difference may be a result of social pressures for men to initiate sexual encounters but to preferentially invest in existing relationships. These patterns, taken together, suggest that socialization can influence fluidity, and in the ways that they are socialized differently around sex and relationships, impact men and women differently.

It is also important to acknowledge that in a society that sexualizes women from an early age, it is generally more acceptable for women to be sexually fluid. Not only are same-sex relationships between women often fetishized or considered erotic, the narrow definition of manhood as being synonymous with hypermasculinity limits men's ability to freely explore the waxing and waning of attractions. Due to the binary nature of socialization, people who grow up genderqueer, trans, or gender non-conforming are either forced to choose between the sexual

narratives of femininity and masculinity, or are excluded from the conversation entirely [35].

7.3.4 Queer Theorist Perspective

Queer theory as a praxis problematizes dominant society's beliefs about orientation [36]. To queer is to reject, and so as a discipline, queer scholars reject the binary gender schema and the dichotomization of orientations into mutually exclusive categories [37]. Queer theory argues that there needs to be a more expansive and flexible conceptualization of sexuality to include folks at all margins, rather than the oppressive hierarchy of identities and experiences [37]. Definitions, libido, sexual scripts, and meanings are all highly diverse, and identity in itself is fluid. Queer theorists then would push against the need to explore sexual fluidity as a new or unexpected phenomenon [36]. Instead, queer theorists would suggest that the observance of sexual fluidity could serve to deepen understanding of the futility of rigid classification systems and labels, and demonstrate that sexual fluidity is merely a representation of the natural expansiveness of identity.

7.3.5 Non-Western Perspectives

The research on sexual fluidity has primarily been conducted in the USA and has focused on young adult populations that are White, middle to upper-middle class, and enrolled in college. Much of the literature also focuses on people who identify as lesbians, either at the time of study or ever in their lifetime.

The construct of sexual fluidity might be a Western concept, not because fluidity does not exist in other cultures, but it may be a more natural experience that does not require a unique label. For example, practitioners of Candomblé, an Afro-Brazilian spirituality, often describe their sexual orientation as "normal," not requiring further labels or categorizations [38]. Other cultures may have more conservative views on sexuality or clearly defined consequences for attitudes and behaviors outside of heterosexuality and the gender binary. Many nations have laws and religious beliefs that disallow people from expressing diversity in sexuality or gender. Such interdictions may discourage folks from exploring or making known attractions that shift away from opposite-sex relationships.

In some communities, orientation is judged on the basis of behavior rather than attraction [39]. In places like Brazil, Turkey, and Thailand, a distinction is made between those who display non-normative gender expressions and those who initiate same-sex relationships. Folks who are on the receiving end of advances, passive participants, are less likely to be considered as operating outside of heterosexual norms [40]. More permissions may also be given to those who may be judged as participating in these relationships out of deference or need rather than true desire, such as working class people who may have sexual encounters with more financially secure partners of varying genders.

Sexually fluid behavior can provide distinct social functions in some cultures. In areas where women are secluded or not available, young men may experiment with sex with other men as a way to gain experience [40]. They may continue to have same-sex relationships at various stages in their lives, but for purposes outside of romance and attraction. For example, in Melanesia, same-sex relationships serve as opportunities to learn how to perform sexually for a future spouse [41]. In Morocco, fluidity can be an expected part of sexual development and personal exploration [40]. In some regions in India, same-sex relationships provide an opportunity for sexual release for travelers away from home [40].

The influence of colonialization erases much of what could be known about indigenous practices of the world. In nations like Japan, for example, same-sex relationships were commonplace until colonialization by the West in 1868 [42]. Slavery, religious conversions, and the rise of the industrial labor market helped spread sexual suppression across the globe, making it hard to access precolonial sexual mores [42]. Even in researching the sexual traditions of other cultures for this chapter, much has been written from European or North American understandings of foreign cultural contexts rather than truly indigenous perspectives, although more country-specific data are becoming available in a variety of languages.

7.4 Implications for Sexual Health

7.4.1 A Note on Relevance to the Medical Profession

It is important for medical professionals to consider the orientation of their clients. Questions about sexuality can feel outside of the scope of routine examination; however, practitioners play an important role in bridging gaps in health disparities. The LGBT community faces many health disparities, including receiving fewer cervical screenings and having more difficulty accessing insurance; they have higher transmission rates of HIV and certain STIs, and higher risks of depression [43]. The poorer health outcomes of sexual minorities are directly related to medical stigma, inaccessible medical care, and medical professionals' inadequate skill in providing treatment. The field of medicine does LGBT patients a disservice when healthcare professionals do not inquire about orientation to better resource and educate the patients they see. Gathering such data would allow doctors to contribute to the public awareness of patient risk and be useful in helping outreach teams better serve communities.

7.4.2 Opportunities for Increased Clinical Support

As recognition of sexual fluidity increases, there are real world implications for medical providers and allied health professionals. The approach to sexual health must be informed by an awareness of variability in identity, and how sexual fluidity can be relevant to their standard practice.

For all providers and organizations, questions about orientation should include room for self-identification, as there is an ever-expanding list of labels possible for folks to identify themselves at any intermediary point between the heterosexual and homosexual binaries. People should have a way of describing themselves when their experiences may not be reflected by the terms straight, gay, lesbian, or bisexual [1]. Detailed information can be garnered through pre-visit paperwork, including space for folks to self-identify. Sexual information can also be gathered through conversation by simply asking patients how they identify sexually.

Because sexual identity, orientation, and behavior can exist independently of one another, unanticipated health risks may occur if practitioners are not intentional in asking for the information that they are seeking [1, 2]. What information is important to conducting a comprehensive assessment? Often the most significant consideration is of partner choices in order to determine exposure risks and customize safer sex practices. Questions about partner choices should not just ask about the gender of the current partners in a singular sense, but leave room for folks to acknowledge if they are partnering with multiple genders of people (e.g., "mostly, but not exclusively, men," "rarely men," "only men"). Phrasing questions about body parts can prevent some of the data lost when there is a discrepancy between their partners' biological sex and their self-defined gender (e.g., "mostly, but not exclusively people with penises").

Sexual fluidity makes it crucial for these assessment questions to become routine—even though the data may be on record, as attraction changes, behavior may change as well. Being sure to confirm all data are still current gives providers access to the most accurate, current information and can provide the basis for conversation about sexuality issues as needed [2]. When assessments are not able to capture change related to sexual orientation, it is difficult to truly understand patients and their development [13].

7.4.3 Opportunities for Increased Social Support

In addition to the medical implications, research on sexual fluidity raises questions about how to provide support to a person as they acknowledge shifts in attraction and possibly sexual identity. There may not be "obvious" symptoms of dysphoria or identity loss associated with this change, which might be different than other shifts in the realm of sexuality.

The model of "coming out" may not be helpful or possible for everyone. In mainstream LGBTQ discourse, the process of coming out is a stage-based journey that marks a pivotal moment in sexual orientation development [27]. The journey is linear, progressive, and can span many years [44]. The prevailing belief is that it occurs once, first to self and then to the world, and marks a transition from an internal or hidden identity to an external or public identity. Identity disclosure is meant to be a clear statement to announce identity and, from there, to begin to stabilize this identity long-term [44]. In the case of sexual fluidity, identity or attractions may

continually fluctuate over the course of the person's life. It may never be consciously recognized or labeled, may not occur until much later in life than other orientation developments (often being recognized once in a relationship rather than during the adrenal stages of puberty) [45], and may not progress in any particular direction [13]. In this case, what would be the equivalent for sexual fluid persons? If their sexual orientation is stable as their attractions change, would coming out still be a meaningful part of their experience? Would the expectation be that they "come out" with each shift, if they experience more than one in their lifetime? Would there need to be a marked change in expression before a public disclosure? Would unexpressed shifts be considered "hiding in the closet"?

There are many social risks and ramifications of coming out for those who are sexually fluid. Sexually fluid people face similar discrimination and invalidation as LGBTQ people: homophobia, heterosexism, and other forms of prejudice negatively impact their access to care and increase the likelihood of poor overall health and inadequate support [1]. The challenges encountered by non-heterosexual folks may be further compounded for a sexually fluid person due to sexual fluidity being infrequently recognized socially and rarely understood medically. As with queer and bisexual people, sexually fluid folks are often treated simultaneously as "too gay" and "not gay enough" if they fail to align with traditional binaries [37].

Information sharing can be a meaningful strategy for addressing social pains and barriers faced by sexually fluid people. Being aware of resources is necessary to offering support [1]: books or articles, first person essays and narratives, online forums, or in-person community groups are all valuable tools. Referrals to other competent and informed providers is also beneficial to ensuring that the patient continues to receive care that not only takes into account their behavior and addresses presenting complaints, but sees them as a whole person and validates their identities, self-knowledge, and experiences. Local resources specific to sexual fluidity can be difficult to find, so practitioners may need to offer more generalized resources if targeted resources cannot be found. Consider referring to local, national, or international LGBT centers, hotline, and online forums for patients looking for support. Practitioners can also connect with their own professional networks for recommendations for providers with expertise on sexuality. Ultimately, each medical provider is responsible for staying up-to-date on data on sexuality and sexual health. Attending trainings and reading research can fulfill this responsibility.

7.5 Summary

It is generally accepted that sexual identity is a mutable construct; however, some of its components have historically been considered to be more fixed or innate. Such is the case for sexual orientation. The scientific consensus is that one's sexual orientation is inherent or immutable, operating outside of a person's realm of conscious choice. However, attraction, as a key component of orientation, can be malleable and responsive to one's environment. These two systems of belief can be difficult to reconcile. For sexually fluid people, orientation is not rigid and can be expected to

change across their lifespan. For some, these shifts will also change the ways in which they describe themselves. In other cases, their attractions may change but they may still identify with the same orientation. The presence of variability underscores how individual and subjective sexual identity can be, especially for women, who comprise the majority of the sexually fluid population.

In recognizing the changeability of attraction and the subjectivity of identity, the conceptualization of sexual fluidity can push societal understanding of sexuality beyond the commonly described binaries of sexual orientation, allowing for a more complex and nuanced view representative of people's diverse experiences. Sexual medicine is obliged to stay informed about the diversity of human sexuality in order to remain in a position to make effective sexual healthcare a possibility. From a position of patience and curiosity, research on sexual fluidity can be implemented to provide positive outcomes in medical and social intervention.

Box 7.1 Additional Resources: Organizations to Consider

The World Association for Sexual Health Congress

International Lesbian, Gay, Bisexual, Trans and Intersex Association—ilga.org

OUTRight Action International—outrightinternational.org

GLAAD—glaad.org

The Safe Zone Project—thesafezoneproject.com

Rainbow Railroad—rainbowrailroad.com

The Trevor Project—thetrevorproject.org

The International Lesbian, Gay, Bisexual, Transgender, Queer & Intersex (LGBTQI) Youth and Student Organization—iglyo.com

Box 7.2 Key Points to Take Away

Sexual fluidity describes changes to one's sexual identity as a result of changes in sexual attraction. The existence of sexual fluidity is evidence that a person's sexual identity can change not only during puberty, but also across the lifespan.

Sexual identity refers to an individual's understanding of themselves as a sexual being. Personal understanding can be nuanced and complex, taking into account various aspects of self. Sexual identity involves several overlapping dimensions, including *sexual orientation* (an identity marker designated by whom a person is attracted to) and *sexual attraction* (is the experience of arousal or chemistry that a person may feel).

Women may have an inherently more fluid sexuality than men. Physiological evidence, social research, and self-report data all demonstrate women's greater tendency towards sexual fluidity. These findings suggest a decoupling of arousal, partner gender, and orientation for women. Sexual orientation in

women is less tied to gender than to characteristics of the person or relationship.

There are a number of arguments for the evolutionary, socio-political, and cross-cultural significance of sexual fluidity, but ultimately, these perspectives work together to suggest that fluidity is a natural phenomenon that conferred individual and community benefit.

Medical practitioners should consider the diversity of sexual identity in order to better understand patient concerns and mitigate the access barriers for sexually fluid persons. A significant way that sexual identity awareness can be integrated into standard practice is by expanding standard assessments to include questions about sexuality. Examples of questions include open-ended inquiries about past and present orientation, recent partner gender, and sexual behavior. Assessment can happen over the course of conversation or through paperwork.

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Part III

Dealing with Sexual Response Problems: Editor's Notes

The original intent of this section was to provide healthcare professionals with an understanding of the cultural ideas surrounding sexual problems and "illness" so that practitioners could develop cultural competence in their clinical interactions with patients. However, it soon became evident that to even consider issues of diagnosis and treatment, other challenges had to be addressed: some populations are unaware of the concept of sexual dysfunction, others may not realize that various conditions are treatable, and/or still others are limited in their access to sexual (or sometimes even reproductive) health care. Furthermore, healthy sexual functioning is often intertwined with what a society considers normal and appropriate for each of the sexes, which itself is driven by social and sexual scripts.

In Chap. 8, El-Sakka addresses issues of men's sexual health in Middle East regions, pointing out that "behavioral norms and expectations equate masculinity with toughness, self-reliance, strength, and emotional disconnectedness, qualities that associate help-seeking with weakness." Thus, men may avoid seeking treatment for sexual problems and instead develop maladaptive coping behaviors that adversely affect their physical and emotional wellbeing. Even for those interested in seeking help, formidable social barriers exist, including family structure, social and gender norms, and strictures on the time and type of sexual activities—sometimes leading to problems in the consummation of marriage.

In Chaps. 9–11, we glimpse at how other ethnic/cultural regions approach sexuality—these chapters provide the reader with insight into the wide and challenging scope of issues related to sexual medicine in both developing and developed world regions. In Chap. 9, Malik and colleagues consider sexual healthcare in central and south Asia, including discussion of myths that drive sexual practices and of subpopulations that often do not receive adequate healthcare services, such as drug users, transgenders, and men who have sex with men. Cultural traditions that define sexual problems are examined, and several case studies are introduced to illustrate typical problems encountered when dealing with often sexually uninformed populations of the region. In Chap. 10, Rashidien and colleagues delve into sexuality in Western Asia and the Middle East, noting that "Asian and Middle-Eastern cultures take a highly restrictive view on sexual issues, as discussion of sex has always been

and remains a taboo subject within those cultures. Not surprisingly, the practice of sexual medicine and/or sexual healthcare can be challenging in these regions." They discuss a wide range of issues impacting men's and women's concerns about their sexual health and the cultural/learning experiences that have formed them, using several poignant case studies to illustrate their points, and ending with practical information for healthcare practitioners as well as recommendations for changes in healthcare policy in those regions. In Chap. 11, Abdo does a fine job of summarizing the complex sexual situation in cultural traditions that mix indigenous and colonial values in Latin regions of the world. Improving attitudes toward gender equality and communication about sex among adolescents are recognized as critical steps toward better sexual health in future generations. At the same time, existing disparities in education and socioeconomic class continue to place vulnerable populations at risk—in some instances the lack of knowledge regarding the connection between healthy lifestyle and healthy sexuality contributes significantly to a lack of recognition of sexual problems and acts as a further barrier to seeking treatment.

The last two chapters provide unique perspectives regarding culture and sexuality. In Chap. 12, Hall walks the reader through the challenges of implementing psychosexual counseling that is sensitive to individuals holding differing cultural values and norms. In this illuminating chapter, she helps the reader understand some of the do's and don'ts of culturally competent counseling, encouraging professionals to set realistic goals and expectations in working with clients. In Chap. 13, Ferrero Camoletto asks critical and fundamental questions regarding the diagnosis and treatment of a sexual dysfunction, using erectile dysfunction in aging men as an example. Specifically, she queries the extent to which sexually dysfunctional states might be socially "constructed" (e.g., by changing social norms), and counsels healthcare professionals to reflect upon such issues as they work with patients/clients. Both chapters are easy, enlightening, and thought-provoking reads.

8 Middle East Cultural Challenges and the Treatment of Sexual Problems in Men

Ahmed I. El-Sakka

8.1 Introduction and General Context

The Middle East is a very diverse region, with many languages and cultures. While the majority of inhabitants of the region speak Arabic, several Middle East countries are not majority Arabic speaking, including Turkey, Iran, and Israel. A region may be defined by physical geography, for example, areas bordered by mountains or rivers or seas, or areas that share a similar climate. They may also be defined by characteristics of human geography, such as shared historical experience, the same language, the same religion, or similar cultural practices. In the case of the Middle East, both physical and human geographic considerations are brought to bear to define the region. This area has a long shared history and religious tradition, being the birthplace of the three main monotheistic religions of Judaism, Christianity, and Islam. Within the larger Middle East region, one can also describe sub-regions, such as North Africa or the Levant, which share certain characteristics. The Gulf countries of Bahrain, Kuwait, the United Arab Emirates, and Oman are linked by shared history, language, and religion within the region. The exact roster of countries considered part of the Middle East region is often debated, but most experts agree on membership of specific countries in the region (see Box 8.1).

Likewise, many experts include the other countries of North Africa—Libya, Tunisia, Algeria, and Morocco—because they are also Arabic speaking and their history and culture are tied to those of other Middle Eastern countries. Turkey is often included as well—in fact, it is often referred to as a bridge between the Middle East and Europe (Teach MidEast: Educational Initiatives of The Middle East Policy Council) http://teachmideast.org/articles/what-is-the-middle-east/.

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Box 8.1 Countries Generally Considered Part of the Middle East Region

- Bahrain
- Egypt
- Iran
- Iraq
- Israel
- Jordan
- Kuwait
- Lebanon
- Oman
- The Palestinian Territories
- Qatar
- Saudi Arabia
- Syria
- United Arab Emirates
- Yemen

Nearby countries sometimes included in the Middle East:

- Turkey
- Morocco
- Algeria
- Libya
- Tunisia

8.2 Culture and Sexual Healthcare in the Middle East

"Culture" is the patterned way of life shared by a group of people that distinguishes it from other such groups [1]. Beliefs and practices associated with culture—and the problems linked to the negotiation of these beliefs and practices—differ in various parts of the world, in some instances creating challenges to treatment. Modifying such beliefs and practices in an attempt to reduce the treatment challenge, while important in some instances, may in other instances end up being wasteful, counterproductive, and/or even unethical [2]. Thus, rather than attempting to change mores or beliefs, a more parsimonious approach may involve adapting medical communication and interaction to accommodate the traditional cultural values indigenous to the Middle East.

Within Middle East populations, little is known about how individual and sociocultural factors interact with an individual's social context (i.e., neighborhood disadvantage, differential access to care, economic resources) to influence treatment-seeking behaviors [3]. Religious, social, and national backgrounds in the Middle East vary greatly, and because the Middle East sits at the nexus of Western and Eastern civilizations, cultural barriers to the treatment of sexual problems vary greatly across the region. For example, although virginity at marriage is almost

uniformly desired in all countries in the region, the practice of polygamy is accepted in some countries yet quite unusual in others. Masturbation myths are still common, and the presumed benefit of female genital mutilation (female circumcision) is widespread. Male circumcision is a standard practice in all Middle Eastern countries.

To illustrate the kinds of challenges inherent in the treatment of sexual issues in the Middle East, one need only look at the situation of erectile dysfunction (ED). ED is a worldwide health problem, with the affected population projected to reach 322 million by 2025. Unfortunately, in most Middle Eastern countries, no solid data on true prevalence rates for ED are available. Yet anecdotal reports suggest a high rate of ED within various age groups and in patients having various comorbidities. In cross-sectional office-based studies in the Middle East on large samples of men, rates of both ED and ED risk factors were found to be very high. Overall, 92.6% of patients above the age of 50 yrs had some degree of ED, 50.8% reported premature ejaculation, and 7.6% reported low sexual desire. Of patients reporting ED, 10% had mild ED, 40% had moderate, and 50% had severe ED [4, 5]. Moreover, about 20% of the patients presented with psychogenic ED, while 80% presented with organic causes. The prevalence of ED in the Middle East ranges from 20 to 90% in patients with various risk factors and medical comorbidities. This wide range of prevalence of different severities of ED is due to the fact that studies were conducted at different times, in different settings, and on populations of different ages, making it difficult to compare findings across studies. The most common risk factors include smoking, obesity, type 2 diabetes, hypertension, dyslipidemia, coronary artery disease (CAD), and depression. Other risk factors less strongly associated with ED include lower household income, physical inactivity, caffeine consumption, use of recreational drugs, alcoholism, and drug addiction. The high prevalence of severe ED in patients in this region may be attributable to the high prevalence and poor control of such risk factors as noted above, the delay in seeking medical advice, and non-compliance with treatment [6–8].

Many reasons have been identified for the reluctance of Middle East people, both men and women, to discuss any types of sexual problems with healthcare providers. These include lack of time, feelings of shame, and the assumption that the healthcare provider could not provide any remedy [9, 10]. Beyond basic shame and embarrassment, other barriers that inhibit patients from seeking treatment for sexual problems include the impression that sexual problems are not "serious," a lack of awareness regarding available services, and disparities between the assumptions of healthcare providers and the reality of patients' expectations about sexual problems [11]. Many of these barriers result from the dominant traditional norms and beliefs about sex and sexuality in this region of the world [12]. For example, behavioral norms and expectations equate masculinity with toughness, self-reliance, strength, and emotional disconnectedness, qualities that associate help-seeking with weakness. As a result, men may avoid seeking treatment for sexual problems and instead develop maladaptive coping behaviors that adversely affect physical and emotional wellbeing [13, 14]. Such inhibitions are further compounded by the fact that some patients believed that an unmarried healthcare provider would be less understanding

about sexual and marital problems, with patients feeling guilt/shame about sharing such issues with them [15].

Another example of the challenges of sexuality in the Middle East lies in the assumptions surrounding aging and sexuality, where research has found that most people associate sexual interest and activity mainly with younger ages. Despite international efforts to dispel this myth—in 2012, the World Sexual Health Organization modified its slogan from "Youth sexual health" to "sexual health for all"; (http://www.worldsexology.org/news/world-sexual-health-day/)—attitudes about sexuality and aging are still strongly governed by erroneous beliefs and cultural taboos. Public opinion, both globally and in the Middle East, presumes that older people are asexual, or that if they do have sexual relationships, they are monogamous [16]. Yet, research has shown that sexual intimacy is an integral part of people's lives irrespective of age [17]. Just as with younger people, however, the elderly having sexual performance issues need to devote quality time with their longtime partner in order to overcome the frustration often associated with the problem, and to overcome the problem itself [18]. Despite increased life expectancy and a growing elderly population in Middle Eastern countries, information about sexuality and aging has been scarce or non-existent [19], with discussion of sex-related topics still taboo in more conservative societies [12, 20–22].

8.3 Challenges to the Treatment for Sexual Issues in the Middle East

Studies identifying cultural challenges affecting the treatment of sexual problems are few and far between worldwide, and even fewer for Middle Eastern populations. Nevertheless, a number of factors specific to the region and its cultural background appear to affect treatment seeking for sexual problems in the Middle East. Some such factors include family structures, social norms and gender differences, marriage and polygamy, sexual practices, masturbation, circumcision, unconsummated marriage, and lack of sexuality education (Table 8.1).

Family Structure Family structure in the Middle East is characterized by strong bonding, which has both positive and negative aspects. Within the local culture, the actions of an individual family member may carry honor or renown for the entire family within their surrounding community. Women, especially mothers, carry

Table 8.1 Cultural barriers of sexual problems treatment

• Family structure
• Social norms and gender differences
• Marriage and polygamy
• Masturbation
• Circumcision
• Pornography
• Unconsummated marriage
• Sexually transmitted infections
• Educational and economic barriers to treatment

much of the responsibility within the family. They most often are dedicated to rearing the children and in doing so may neglect their own needs. While such devotion to the family is expected of family members (especially women), it may also become counterproductive should family needs be given precedence over community interests [23]. On the positive side, a strong family support system often ensures that wealthier individuals in the extended family support less privileged family members. Such family issues, although often facilitating, have also been reported as barriers to the treatment of sexual problems in Middle Eastern countries. For example, dominant family members decide who should or should not be treated and may overrule an individual's need for treatment, an issue exacerbated when sexual healthcare is involved.

Social Norms and Gender Differences Even as boys are gaining greater freedom regarding issues of sexuality in Middle Eastern countries, girls are generally overprotected. For boys, premarital sexual experiences—although prohibited and uncommon—do not seriously complicate their marriageability. The husband is generally responsible for earning the income to support the family, while the wife is the manager of the home and responsible for raising children. Due to the overprotective nature of the family, especially toward women and those of younger ages, many family members are prevented from seeking help when they need it: sexual healthcare is generally considered unneeded or inappropriate for unmarried women or youth [24].

Marriage and Polygamy Marriage is the only accepted context for sexual activity in most Middle East countries. Families are keen to marry off their sons and, even more so, their daughters to enhance their social image within the community. The education level, social backgrounds, and standard of living control the shape and level of marriage. In certain regions of the Middle East, as in the gulf countries, it is considered normal and socially acceptable for a man to take more than one wife, often up to four. In contrast, polygamy is socially unacceptable—although not illegal—in most other areas of the Middle East. Failure to consummate a marriage for whatever reason is considered grounds for divorce or annulment of the marriage. Virginity for both men and women at marriage is considered essential in most Middle Eastern countries, as religious and social norms dictate premarital chastity. Especially pertinent, a woman involved in premarital sexual relations is considered to have lost her honor and disgraces her family [25]. Due to the general assumption of premarital abstinence, men and women are not free or expected to overtly seek premarital medical advice or help, even if they feel they have a sexual problem.

Pornography and Masturbation Pornographic materials are not legally available or widespread in most of the Middle Eastern countries. Some countries even block pornographic websites. Furthermore, prostitution is legally banned in most Middle Eastern countries. As in other parts of the world, masturbation is presumed to be a common sexual practice among males in the Middle East, yet myths surrounding masturbation abound in Middle East countries. Such myths suggest that

masturbation leads to sexual impairment, weak eyesight, damaged knees, trembling hands, inflammation of the prostate gland, and general weakness. These beliefs often result in feelings of anxiety, distress, and guilt. Yet, male masturbation is the most commonly raised subject about sexuality by young men, and among many, the topic is a source of continuous and impassioned debate. Young men typically ask about its complications and consequences, and worry that their history of masturbation may weaken them and interfere with good sex or even treatment for sexual problems. In contrast, female masturbation has garnered little mention or discussion in Middle Eastern countries, presumably because it is not a common practice. Although masturbation is religiously and socially prohibited in many Middle Eastern cultures, others in the medical community in the Middle East consider this practice a safe outlet for adolescents wanting to relieve sexual tension [25].

Circumcision Male circumcision is practiced by almost all Middle Eastern countries. Unfortunately, female genital mutilation (circumcision) is also practiced and perpetuated by local myths in many countries such as Egypt and Sudan, despite the advice of religious and social authorities against the tradition [25]. Women in Middle Eastern countries who have undergone female circumcision may be reluctant to engage in sexual activity and even more reluctant to seek treatment for any sexual issues that might result.

Unconsummated Marriage Unconsummated marriage—also known as honeymoon impotence—is considered a significant problem and accounts for a high number of visits to sexual health clinics in conservative Middle Eastern societies. Psychological factors, particularly performance anxiety in men and vaginismus in women, are the main causes of unconsummated marriages in these countries. Organic etiology related to vascular, neurological, or endocrine disorders appears to be the cause of unconsummated marriages in only a minority of cases [26].

A fairly high prevalence of honeymoon impotence (17%) among ED patients has been reported in Saudi Arabia [27], and a somewhat lower rate (8%) has been reported in Egypt [28]. The overall magnitude of the problem, however, warrants greater public attention and strongly suggests the need for sex education programs to help young men and women understand and cope with this problem in conservative societies in the Middle East.

A number of cultural challenges regarding unconsummated marriage have been recognized, with healthcare providers treating patients with ED in some conservative societies facing unique challenges. Newly-wed couples in such societies often have limited premarital sexual experiences. Although this is intended to make the wedding night a very special event, men are often under strong pressure to perform, and in failing to consummate their marriages, they experience a significant amount of stress. Not only do they suffer embarrassment in front of their wife, but possible humiliation from the bride's entire family as well [29].

At one time, patients presenting with unconsummated marriage who failed to respond to behavioral therapy were, after exclusion of complicating female factors, offered intracavernous injection of vasoactive substances or penile implants [29].

As effective oral treatments for ED became available, PDE-5 inhibitors became the first line treatment for this syndrome [26–28]. Contemporary approaches to the treatment of unconsummated marriage in some Middle Eastern clinics often include a combination of sex therapy and oral erectogenic medications [30, 31]. However, an ongoing problem is that counseling therapy is not readily accepted in many parts of the Middle East, and since both men and women are often reluctant to seek couple's counseling, effective combination therapies are often bypassed. Even when couples are persuaded of the value of combination therapies, compliance regarding homework exercises tends to be low, offering little added benefit to the couple [29].

8.4 Barriers to Initiating Dialog About Sexual Health

Despite the high prevalence of sexual problems in the Middle East, healthcare providers, including general practitioners (GPs), often avoid discussing sexual concerns even when a problem may be suspected. Healthcare providers may be concerned that such discussion will be both embarrassing and time-consuming, the latter referring to issues of time pressure, effort, and reimbursement potential [32]. In addition, they often feel that they lack the necessary knowledge and skills for such conversations. Such factors often prevent the healthcare provider from opening a dialog with a patient about sexual issues, especially the case when the healthcare provider has felt that sexual health was not a priority issue, and when they have felt some discomfort in dealing with the topic.

One informative European study has identified a number of physician barriers to discussing sexual health with patients. Attitudes and beliefs were considered the most important barrier, closely followed by lack of time, both to deal with the issues themselves and to obtain the information needed for diagnosis and decision-making. Lack of training, experience, and fear of failure were also considered relevant [33]. In a British qualitative study, lack of time, lack of training, and issues with particular patient groups were identified as relevant barriers [34]. In a study specifically about ED, physicians identified lack of knowledge and skills and emotional inhibitions as relevant factors [35]. A cross-sectional study in Ireland reported lack of awareness, knowledge, and confidence in addressing sexual problems as major barriers, with lack of time, feeling the patient was not ready, and lack of training in the area as considerations as well [36]. In a study on management of sexual dysfunction in women, time constraints and lack of effective therapies were considered important barriers to initiating discussion about sexual issues [37]. Given the many physician barriers identified in regions of the world where inhibitions regarding open discussion of sexual issues are much lower, it is not surprising that such factors, perhaps intensified in Middle Eastern contexts, likely contribute to the reluctance of practitioners and patients to engage in meaningful discussion about sexual issues in the office or clinic.

In an effort to overcome such barriers, an observational study in France of urological and psychiatric hospital appointments for ED emphasized the importance of

promoting methods of interaction that facilitate doctor–patient cooperation [38]. In fact, the healthcare setting provides opportunity for interaction about sexual health issues, but such interaction is greatly influenced by the cultural background of the health professionals, which in turn plays a crucial role in the way the disease is conceptualized and treated [39]. For example, Western medicine involves an analysis of ED symptoms and underlying causes that contribute to ED, while traditional and complementary medicines in many parts of the world emphasize the necessity of holism and harmonization of body organs to achieve a natural (healthy) sex life. Regarding treatment strategies, traditional and complementary medicines focus on restoration and improved body regulation through the use of various herbal and animal products, strategies that may have some utility and acceptance in the treatment of ED in some Middle East populations [40, 41].

8.5 Sexual Dysfunction in the Middle East

A cross-national survey carried out in six Western countries indicated that most men with ED do not seek treatment, with the qualification that desire for or interest in sex was typically necessary before they would even consider it. In addition, younger-aged men were least likely to seek treatment [42]. Yet ED affected men's feelings about themselves and their partners, their treatment-seeking behaviors, and their treatment compliance [42]. Although reliable data regarding the prevalence of male sexual dysfunction in the Middle East are not available, many anecdotal reports regarding male problems have been reported. According to such reports, both ED and premature ejaculation (PE) appear to be highly common among male patients. Furthermore, risk factors for ED (such as smoking, obesity, diabetes, and dyslipidemia) are commonly found among ED patients [6–8]. When office-based patients in the Middle East are compared with the age-matched ED sample in the MMAS study (in the USA), severe cases of ED appear to be much more prevalent in the Middle East sample [43]. This high prevalence of severe ED in Middle East men may be due to several factors, including the high prevalence of risk factors such as smoking and obesity. The incidence of smoking among Middle East patients is unknown; however, 38% of male physicians in some local areas were smokers [44], compared to only 8% in a comparable group in the USA, suggesting that overall tobacco use may be much higher in the Middle Eastern population than, for example, in the West. In addition, the Middle East has a high prevalence of comorbidities associated with erectile problems, such as diabetes, hypertension, ischemic heart disease, and dyslipidemia. For example, the prevalence of diabetes appears to vary from 6.5 to 30% in the male Saudi population [45], substantially higher than the prevalence of diabetes in the West, estimated at 5%. A high calorie diet and sedentary lifestyle may be exacerbating factors for both diabetes and ischemic heart disease in the Middle East.

Other factors that may contribute to the high prevalence of severe ED in the Middle East include: (1) the delay in seeking medical advice, (2) the poor control of diabetes in this population, (3) failure to comply with treatment, and (4) the high

number of complications associated with ED complaints within office visits [6–8]. In essence, the high prevalence of severe ED in the Middle East may be related to broad health-related issues that include diet and lifestyle variables. Together with poor treatment-seeking habits and low compliance, the high prevalence may partly result from a combination of healthcare-related behaviors that maximize risk and minimize adequate treatment.

Sensitivity to Cultural Issues In issues involving ED, the healthcare provider needs to demonstrate an appropriate sensitivity to issues that vary across nationalities and cultures [46]. By putting the patient at ease, the physician will find it easier to uncover any barriers and/or challenges that could hinder management of those patients. Thus, integrating the understanding of psychosocial issues with prescription of appropriate pharmaceuticals to treat ED is key to a comprehensive treatment approach [47, 48]. A thorough understanding of patients' attitudes and beliefs can help the physician provide better treatment by including the individual patient's concerns into a prospective management plan [46].

As an example, Malaysian and Chinese men tend to blame their wives for their ED. They are also fearful that their ED might lead their spouse to seek an extramarital affair [49]. Yet a multinational study of over 2900 men with ED found that many men were unlikely to seek treatment for their ED, as they believed that treatment medications were dangerous or that their ED resulted from stress or the need for a healthier lifestyle [50]. Thus, although these men had strong motivation to deal with their ED, their contextualization of their problem prevented them from seeking help. Although attitudes and behaviors identified through such surveys may not always reflect actual attitudes and behaviors encountered in the clinic, physicians still need to be aware that such attitudes might affect communication and disclosures in the medical office [46]. For example, a physician who asks a man about his sexual functioning in order to ascertain the potential for cardiovascular problems might well encounter denial on the part of the patient for the kinds of reasons given above.

8.6 Sexually Transmitted Infections

Awareness of sexually transmitted infection (STI) is very low among the general public in the Middle East [51]. Middle Eastern authorities initially denied the AIDS threat, [52] and, as a result, blood transfusions and imported blood products accounted for many initial AIDS cases. Other groups such as injecting drug users, hemophiliacs, blood transfusion recipients, and healthcare workers also were subjected to major risk. A lack of recognition of the AIDS problem and underreporting are likely to be common in many Middle Eastern countries.

Failed efforts toward AIDS prevention stemmed not only from low awareness, but also from various cultural attitudes and practices. Marital infidelity and unsafe sex create significant risk for transmission of the virus from one sexual network to another. On the other hand, other practices may have helped to prevent the spread of

AIDS. For example, sexual cleansing—the practice of a girl or woman having sex after her first period, after being widowed, or after an abortion—and dry sex are incompatible with safe sex. Given such risks, health care providers in the Middle East need to adopt strategies to AIDS prevention that are meaningful to the local populations, including, for example, those mentioned above [2].

Some countries in the Middle East are now conducting sentinel surveillance (i.e., monitoring the rate of occurrence of specific conditions to assess the stability or change in health levels of a population) on limited numbers of STI patients attending public clinics in the Middle East [52]. The World Health Organization (WHO) has been helping health organizations in the Middle East to establish a system to differentiate between simple surveillance and actual case findings and outcomes. Barriers to STI care include the need for husband's permission to seek treatment, cost, confidentiality concerns, long waits in public clinics to get an appointment, and fear of a judgmental attitude on the part of the healthcare provider [25]. Overall, such findings may represent obstacles and barriers to seeking medical advice and further highlight the importance of location-specific strategies aimed at increasing prompt care-seeking at qualified medical facilities. Furthermore, the lack of knowledge about STI transmission appears to be a serious problem. For example, studies in Africa have shown that only two of three patients with documented STIs knew that infections and diseases could be transmitted through sexual intercourse, and only one in three non-STI controls understood this process [51]. Moreover, and somewhat disappointing, in one study, STI awareness did not appear to affect people's lifestyles, as more STI-aware persons were actually more sexually promiscuous than unaware counterparts. Therefore, urgent health education campaigns are critical to changing people's attitude regarding the spread and control of STIs in emerging countries, including those in the Middle East [25].

A clear example of what can be achieved with respect to STI's is seen with the Hepatitis C virus (HCV). This condition used to be endemic to some areas of the Middle East such as Egypt and Saudi Arabia, with an overall frequency of 5.3% or higher in healthy adults and at least five times higher than in Western Europe and the USA [53]. However, after adopting an HCV national screening program, implementing effective treatment, and identifying cultural and other challenges related to HCV elimination in the affected countries, the near future is expected to bring a significant reduction in HCV prevalence [54].

8.7 Educational and Economic Factors that Affect Treatment of Sexual Problems

The introduction of less invasive techniques for ED treatment has greatly altered the potential for effective treatment, underscoring how treatment options may increase treatment-seeking behavior. Specifically, less invasive but effective intracavernosal injection, vacuum constriction devices, oral PDE-5i's, and more recently gene and stem cell therapy and extracorporeal shock wave therapy (ESWT) have dramatically

increased the options for ED treatment. Informing and educating both the patient and partner of the available diagnostic and therapeutic options is an important aspect of the office consultation. Nevertheless, although correcting the underlying etiology of ED seems to be the most logical approach, the current socioeconomic climate may present a major obstacle, as the cost for diagnosis and treatment of ED remains high and out of reach for many Middle Eastern men. Finally, many clinicians have adopted a goal-directed approach in their clinic, based on the patient's presenting complaint. This strategy, while having certain benefits, also typically limits the extent of further workup and investigation [55, 56]. Such limited investigation might well—depending on the patient's age and general health [36, 37]—miss important symptoms related to broader issues of sexual and general health.

8.8 Conclusion

A better understanding of the attitudes of men and women regarding sexual health and dysfunction will help place each patient's attitude into proper context, allowing the physician to recognize when a sex coaching approach may work. Recognizing attitudes, barriers, and challenges that might delay treatment seeking or interfere with compliance will also help the physician accommodate a patient's personal preferences and is likely to improve patient satisfaction and quality of life [46, 57–60].

In this chapter, we attempted to elucidate the various barriers and challenges in the Middle East that impact the treatment of sexual problems, particularly with reference to men. The Middle East region includes different cultures with diverse beliefs and attitudes, not just across countries but often within a given country. The predominating cultural barriers are thus quite variable and may differ from one region to another—yet all regions could benefit from targeted sexuality education.

At the same time, it is important to recognize the common aspects of sexual health problems. That is, sexuality and its problems are not exclusively culturally relative, but rather share many common elements across cultures. To limit one's own study to a specific ethnic group implies that a specific health problem among this population is vastly different from the same problem in the neighboring group, as though different risk factors and etiologies apply to the same problem across different ethnicities and cultures. Despite this, it is still important to tailor communication and dialog so it is culturally acceptable to the local population, so as to allow that population to decide collectively what issues they deem important and how those issues should be managed [2, 61–63].

Finally, we note the need for additional research exploring and dealing with cultural challenges that occur in the Middle East. Much of the available research on such topics has had limited generalizability, as sexual activity for single and widowed men or women is culturally unaccepted and legally prohibited; that is, studies in this part of the world have been able to recruit only married men or women [64]. Yet, future research may experience challenges tapping into unmarried populations—not only is such activity taboo, but discussion of sexual parameters by

woman—married or unmarried—is often considered inappropriate if not outright sinful. Nevertheless, women's sexual health issues, including those of both the married and unmarried, need better documentation, as the sexuality of such "hidden" groups is important to understand.

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Challenges in Sexual Issues in South Asian Populations

9

Tamkeen Ashraf Malik, Hira Liaqat, and Ahmed Bilal

9.1 Introduction and Context

South Asia is home to around 25% of the world's population. More than 45% live under the absolute poverty line of 1.25$ per day, while occupying only 3.5% of the world's land surface area [1]. South Asia is the most densely populated region in the world and fares better only compared to the African Sahara region in terms of poverty. Poverty is one of the primary causes for the debilitating health situation in South Asia and it continues to rise unhindered, owing primarily to the lack of sustainable infrastructure and the inability to harness the massive human capital available to the region. Among South Asian countries, Sri Lanka has a relatively better health care system, as its citizens are provided free medical and educational benefits since its independence in 1948 [2]. Other countries, led by Bangladesh and Afghanistan, have been hit hardest by healthcare issues in general and sexual healthcare issues in particular [3]. This situation is partly due to political and economic instability and hence a lack of focus on health in war-ravaged Afghanistan, and overpopulation and malnourishment in Bangladesh.

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Box 9.1 Key Contextual Factors

- With its many other challenges, sexual health has low priority for government and people alike in the Asian subcontinent.
- Sex is both mystical and profane. While the topic of many jokes, serious talk about sexual rights and health is taboo.
- Shame and guilt are strongly associated with sexual issues.

9.2 Sexual Healthcare Issues in the South Asian Context

Sex has always been an area of much intrigue and fascination, especially in South Asia. One reason for this fascination can be traced to the covert nature of everything related to sex. Unlike any other physiological regulatory processes (e.g., eating, sleep), the topic of sex has historically been taboo. Though religion is partly responsible for secrecy surrounding sex, the overall nature of the family structure in South Asia, with its foundation in the differentiation between the sacred and the profane, may be the major reason—sex lies on the border of both domains. As a path towards bringing life onto the Earth, sex has been considered sacred, and like all sacred things, sex has received a venerable status, not suitable for mundane daily discussion due to its ritualistic and partly mystical existence. On the other hand, due to the mechanics and resultant orgasmic culmination of the sexual act, certain inclinations have linked it to the profane. Hence being mystical and profane, it is not a worthy or suitable topic for daily discourse.

Discussion about sexual issues in the contemporary pedagogical domain is a challenge, especially for the young populace. Inclusion of sex education in the school curriculum has received mixed reception from parents and other stakeholders alike. Parental perception of risk attached with sex education, teachers' inhibitions about talking about a taboo topic, and the curriculum devisor's challenge to provide age- and gender-appropriate information are only several of the challenges hindering the provision of sex education in school settings. Adding elements related to cultural and religious traditions further exacerbates the difficulty of securing potential acceptance of the narrative [4, 5].

Sex education helps youth deal with the issues of sexual health more effectively and also helps prevent negative outcomes related to sexual health, with youth opting for better practices in their own lives and potentially reducing sexual crimes in society. Although global incidences of sexual crime, especially against women, are not in decline, certain variables specific to South Asia are unique to this problem. Among them, the issue of shame is highly localized to this region. The upbringing of children in this region of the world still harkens to the old ways, especially among the rural populace. Children, especially girls, are brought up fearing for their chastity, with every stranger being a potential harasser, every wrong turn towards a dimly lit alley potentially leading into a life of shame [6, 7]. Our intention here is not to paint the entirety of South Asia as a landscape of perversion and misogyny. However, the narrative discussed at homes portrays a not-so-friendly picture of the world outside the walls of the house, especially for women.

Box 9.2 Exacerbating Conditions

- Children are at high risk of sexual assault due to parental lack of knowledge regarding sexual rights and health.
- Sex education programs are not offered at schools, so youth have limited information about sexuality.
- Resistance from clergy contributes to the suppression of a sexual health curriculum.
- South Asia is known for the belief in the powers of aphrodisiacs.
- Stereotypes prevail such that sexual power is directly linked to masculinity.

Therefore, sexual crime against women, if brought to light, renders the women culpable to social ostracization [8]. As a result, a large numbers of cases of varying degree of sexual assault on women go unreported. The effects of such repression are often visible later in life, especially at the time of marriage where the women may exhibit aversion to the notion of consummation of marriage.

Parents find it difficult to talk to their children about sexual issues, which puts the children at risk. First, the children/youth might not know which acts by an aggressor count as "*sexual*" in nature, and second, they might not know how to protect themselves and involve their parents in dealing with any aggression or trauma that might occur. The possible inclusion of teachers into the educative segment may ease the parental burden. Naturally being close to the children for hours at a time, teachers are adequately equipped vocationally, and emotionally, to invest in the safety of the children. However, the argument raised by the religious sector that sex education might incite premature sexual maturity and sexual activity hinders the process. The need, perhaps, is to bring the religious segments of the society into the fold by allowing them to understand that sexual education for safety does not equate with promoting vulgarity and profanity among the youth [8, 9].

Furthermore, children suffering from sexual abuse have a difficult time finding words to describe their ordeal. The problem increases with younger age where the child's vocabulary is also insufficient to describe a problem. Consequently, parents might be unaware of the nature of the problem of the child, as the presenting complaints are either too diffused or scattered.

9.3 Myths Regarding Sexual Practices

An issue prevalent to Asia in general and South Asia in particular is the belief in the powers of aphrodisiacs. Many people believe that the consumption of rare and expensive aphrodisiacs (e.g., *shilajit:* mountain tar) is associated with increased immunity, reproductive capacity, increased libido, and a cure for erectile dysfunction [10]. Obtained from the mountainous regions along the Himalayas, *shilajit* has been extracted at steep elevations during the summer when this resinous substance oozes out of cracks in the mountains. It is a coveted substance and is quite in demand, especially among the tourists venturing to northern parts of Afghanistan, Pakistan, India, and Nepal.

Similarly, a type of lizard, Saara hardwickii (*Sanda*), indigenous to Thar Desert between India and Pakistan but also found in some arid areas of Saudi Arabia, is a reptile having supposed medicinal value for treating sexual dysfunction in men. The fat of this lizard is boiled and applied to the male genitalia in order to increase libido.

Case Study 1
A client suffering from performance anxiety and apparently responding well to therapy cancelled his next sessions, citing a medicinal fix to his issue. Three days prior to his marriage, the young man frantically called and sought an appointment. Upon inquiry it was revealed that the young man heard of *Sanda* oil and requested his cousin to acquire some for him. The cousin obliged and went to the lizard market at the outskirts of the city and procured a vial of said oil for him. Upon receiving the package, the anxious groom-to-be applied the oil hoping for an increased libido and sexual timing. The oil caused severe acne and swelling to his genitalia and the man was hospitalized soon after.

Also, with particular regard to the attitude of South Asian men, first time sexual intercourse is associated with inherent fear and anxiety. The female anatomy elicits apprehension which is then linked with the theory of self, that if one is not able to sexually satisfy his partner, then something is inherently wrong with him. And because most sexual activity, especially among the morally or religiously upright individuals, happens after marriage, there is little to no prior experience of having sex. To compensate for potential lost ground, these sexual medicines/response enhancers are taken with the hope of bringing the sexual partner to a climax before one's self. The issue of increasing libido is resolved by seeking clinically dubious medication and following methods of quacks and *hakims* (those who practice traditional medicine in Indo-Pak culture).

Diabetes and hypertension along with a sedentary lifestyle are linked to decreased sexual and erectile capacity [11, 12]. As a large percent of the population is unaware of their diabetic condition, sexual dysfunction is often misattributed to other causes; hence, remedial methods are frequently employed which do not address the root cause of the problem. Evidence suggests that a healthy active lifestyle with a balanced diet is perhaps the best guarantor towards a healthy sexual life. However, lack of such information and a further lack of compliance in following such advice appear to contribute to problems of sexual health of men in South Asia.

Another problem arises from the general belief and the imagined link between sexual virility and masculine identity. An analysis of humor in this region of the world would reveal that the prime punchline of jokes is concerned with sex, often related to the idea that a sexually powerful performer is one who is respected and revered by his wife/spouse/mistress and who will thus also be obedient to him. Conversely, the sexually weak person has no respect from his wife/spouse/mistress [13]. Hence, from a young age boys are preoccupied with fulfilling the script of being sexually strong.

9.4 Key Populations Affected in Asia

The following populations suffer the greatest disadvantage from unprotected sexual practices in the Asian subcontinent.

Box 9.3 At-Risk Populations and Barriers to Seeking Help

- Lack of awareness, access to value-free medical care, and fear of stigma puts the subgroups like MSM, drug users, transgender people (including transvestites, castrati), and sex workers at higher risk for STD contact.
- Women are reluctant to seek help, and little is known about the issues they face and how they deal with them.
- Reproductive health of women is accompanied by fears and myths which also affect the sexual behavior of the woman during critical stages of pre- and postnatal periods.

9.4.1 Men Who Have Sex with Men (MSM)

Compared to the general population, men who have sex with men (MSM) are 28 times more likely to have HIV [14]. The increased prevalence of sexually transmitted infections (STIs) among the MSM group owes to the inconsistent use of condoms and the nature of MSM contact [15]. Compared to vaginal sex, anal sex typical of MSM is riskier in terms of fluid exchange, as the inner lining of the anus is thinner and more susceptible to tearing.

The attitude towards MSM varies across south Asia; and in certain regions, it is not even considered as homosexuality. For example, in certain places, including but not limited to Afghanistan and the frontier regions of Pakistan, older men having sex with young boys is not considered homosexual. In contrast with typical male–female sexual encounters which are largely private affairs, MSM encounters may involve group affairs wherein multiple men gather to have sex with a number of partners at a given time, with condom use reduced or absent and the risk of STI exposure increased. A large percent of MSM are generally unaware of their STI status and hence see no reason to be screened and treated for a possible infection. However, these practices are only common in certain pockets of South Asia. A large region of South Asia subscribes to Islam, including Afghanistan, Pakistan, Bangladesh, a significant part of India and Sri Lanka, and pockets in Maldives and Nepal. Islam carries strict punitive measures for sodomy, including stoning. Such religious interdictions drive the issue underground, as services for MSM are not mainstreamed and, owing to the possibility of being caught, a large portion of MSM opt against screening for infection. This lack of screening further increases the risk of STI transmission [16]. Furthermore, the social isolation resulting from being a pariah in an otherwise largely heterosexual society serves as a cause for anxiety and severe depression for those with MSM inclinations. Social isolation and a lack of a support system are among the major causes of the increase in STI infection among the MSM group [17].

NGOs focusing on sexual health and rights are usually the only health service providers catering to the MSM demographic, and these organizations face multiple difficulties. It is not easy to situate, coordinate, and execute plans for male-focused

sexual health programs. As an alternative, the use of telephone helplines set up by certain NGOs in collaboration with the International Planned Parenthood Foundation (IPPF) has reportedly been successful, for example, Rahnuma-FPAP in Pakistan, "Sahaay" in India, among others [18]. Due to the stigma attached to MSM activity, it is not easy for MSM with medical ailments to contact their local medical service provider due to fear of being exposed. Helplines, on the other hand, allow for anonymity, and helpline therapists can link clients with a partner medical facility provider. This option helps provide access to necessary medical services for this population. Working together with medical health providers, therapists at such organizations offer counseling services as well, which then spread knowledge of the services by word-of-mouth through the MSM community. Although the MSM community is largely a financially impoverished segment of the society with limited access to health care services, among the well-off and educated segment of this population, obtaining the required services (e.g., testing for HIV and STIs) along with other medical assistance is generally not very difficult. And because of their level of education, these individuals are less likely to pass their infection to others. NGO and government sector programs focus mainly on the marginalized, less knowledgeable, and more vulnerable segments of society for both treatment and reduction in STI transmission.

9.4.2 People Who Use Drugs

Intravenous drug users (IDUs) are at a high risk for developing STIs. The highest prevalence of undetected HIV cases is among drug users in general and destitute drug users in particular [19]. Drug users sharing needles are the prime bastion of STI transmission. The connection between drug use and HIV and other STIs is twofold. One is through needle sharing, resulting from a lack of resources to obtain clean syringes and/or a lack of awareness of the need for separate syringes for individual users. The second is related to the other utensils involved in drug use. Even drug users who understand the communicable nature of STIs often do not understand that the needle is not the only source of contamination. Unlike cigarettes, which can be inhaled without the need of any accessory, heroine, amphetamine, and other drugs require utensils for final preparation before needle injection. Often unknown to drug users who may be using fresh needles, contaminated utensils used for preparing the drug for injection can also put them at risk for such diseases (see Table 9.1).

9.4.3 Transgender People (Including Transvestites, Castrati)

Transgender individuals represent one of the most at-risk populations. Their plight comes not only from their difficulty in accessing healthcare services relating to sexual issues, but also to the engraved apathy and collective alienation exhibited towards them by the society at large. In the current world of plurality and multiplicity of sexual identities, this segment of the population in South Asian countries still

Table 9.1 Epidemiology of the HIV infections and AIDS-related deaths in South and Central Asian States, 2016–2018

	New HIV infections			Change in new HIV infections since 2010	AIDS-related deaths			Change in AIDS-related deaths since 2010
Country	2016	2017	2018	2018	2016	2017	2018	2018
Afghanistan	<1000	<1000	<1000	49	<500	<500	<500	45
Bangladesh	1400	1500	1600	56	<500	<1000	<1000	110
Bhutan	<100	<100	<100	−28	<100	<100	<100	−27
Nepal	1100	<1000	<1000	−57	1100	1000	<1000	−37
Pakistan	19,000	20,000	22,000	57	5400	6000	6400	369
Sri Lanka	<200	<200	<200	−52	<500	<200	<200	−25
Iran	4500	4400	4400	−12	2700	2600	2600	8
Kazakhstan	2600	2600	2600	35	<500	<500	<500	56
Kyrgyzstan	<1000	<1000	<1000	−49	<200	<200	<200	55

Source: UNAIDS AidsInfo [20]

remains ousted from the mainstream of social engagement. Transgender people are highly at risk due to the inhospitable environment in which they survive. Usually either they are cast out by their own family or they seek refuge among themselves in clans of transgender communities that do not ostracize them for their sexual identity. In countries like India, the status of transgender individuals has seen a change for the better [21]. However, the change is more on the legislative side, where India has a relatively better presentation in this regard. Pakistan has recently accepted the status of transgender people as a demographic entity and has given them a citizenship status, meaning that a card bearer is now entitled to medical and health facilities at a government hospital. Nevertheless, a large majority of transgender people live outside the system, having limited access to healthcare services [22, 23]. As they have scant economic and employment opportunities, their main sources of income include beggary, dancing at festivities, stripping, and prostitution.

9.4.4 Sex Workers

Sex workers are the most at-risk population for STI and HIV infection. Unfortunately, they are also major carriers, as their clientele is likely infected by hiring their services and thereby inadvertently infecting their own family members. Sex workers are also among the most oppressed segment insofar as marginalization and discrimination. Due to the fear of stigma and discrimination, sex workers are generally reluctant to visit government medical health facilities for screening and treatment. Non-governmental organizations (NGOs) advocating health and safety have realized partial success, as the number of HIV and HPV screenings has increased.

We again find that the lack of education plays a key role in this regard. A significant portion of sex workers are runaways who are cajoled into prostitution by organized rackets using extreme measures to control their workers, sometimes even

chaining up their "merchandise." Living in dark and murky environments, having no place to escape, and lacking in education and awareness are among the key factors contributing to the debacle of sex workers in general.

The laws and social acceptance of sex workers differ across countries in South Asia. They range from the very punitive policies in Afghanistan where commercial sex is prohibited by religion and law, to the legalized sex-worker industry in Bangladesh, which is home to one of the biggest brothel villages in the world, *Daulatdia*. India has also legalized prostitution but in Pakistan, sex work is illegal though still prevalent across all strata of society. Bhutan, Iran, Sri Lanka, and Maldives consider prostitution illegal although prostitution is not necessarily absent in those locations. Places where prostitution is deemed illegal cause more extortion and inhumane treatment for the sex workers. In contrast, in countries where sex work is legalized, there are more opportunities for union formation and negotiations with governments as to the rights of this industry. Prostitution, even if legal, is prohibited below the age of 18. However, girls as young as 14 enter this profession either by being trafficked or because they are victims of abject poverty and misery.

9.4.5 Condom Availability and Usage

The use of condoms is important for the prevention of STIs, including HIV. However, the availability of condoms, though subsidized and cheaply made available by health departments, is of scant use owing to the level of awareness and general attitude of the end users. In-depth interviews with clients from the sex-worker industry illustrate that mere availability and affordability of condoms are not the only issues. Rather, lack of awareness and a negative attitude with regard to usage of condoms as a means to protect from STIs have been challenging, especially among the rural populace. Lack of information and perceived invulnerability from harm are just several factors which hamper the use of condoms, especially by the female sex workers.

Female sex workers face issues of a decreased clientele if they insist on condom use by their male clients. Sexual health-related NGOs are increasing awareness of the problem, though not always compliance, within the sex-worker industry. However, it is still a long way before sex workers are likely to be assertive enough as to pair services rendered to the use of condoms.

9.5 Motherhood Issues

9.5.1 Pregnancy

Pregnancy is a special time for women, one filled with medical, psychological, and social changes that also affect her sexual relationship with her partner. Fears and myths affect the sexual behavior of the woman during this period of life [24]. A decrease in sexual activities during pregnancy has been observed in several studies [25], and although reasons vary, most beliefs are linked to ensuring a successful

pregnancy and the mother's and child's health. Practical concerns are typically related to low energy, emotional states, nausea, and other physical changes associated with pregnancy, but increased anxiety may also be relevant. Decreased sexual interest and increased body discomfort lessen the interest in and satisfaction with sexual activities. In addition, fatigue during the first and last trimesters often leads women to refrain from sexual activities [25–27]. Equally if not more important, sexual behavior is limited among pregnant mothers out of fear of losing the fetus. The fetus is seen as vulnerable and dependent on woman's reproductive health, and its health and survival are ensured by the mother's health and absence of obstetric complications [28]. Despite research indicating no or little association between sexual activities and fetal risk or complication [25, 29] in Asian societies, perceived risk is strongly associated with sexual intercourse during pregnancy. Hence, any and all complications during pregnancy, such as bleeding, pain, infection, and any sort of damage to membrane or fetus, are seen as a consequence of sexual activity during pregnancy [30, 31]. In Pakistani society, the prohibition of sexual activities during pregnancy is seen as an important step towards fetal care, with the belief or practice institutionalized through informal education via folk wisdom of elderly women, midwives, religious and cultural sources of information, and women's own perceptions. Ironically, sexual intercourse during the last trimester of pregnancy is sometimes believed to be beneficial for easy birthing as it widens and brings flexibility in vaginal muscles [30]. But beliefs vary greatly: for example, a study from Iran reports the prohibition of intercourse during pregnancy if the expected gender of the fetus is "female" as it may damage the fetus' hymen [32] whereas research from Pakistan concludes that almost all beliefs held by women about sexual activity during pregnancy, birth, and postpartum are related to ensuring fetal and neonatal health [33–36]. Thus, Pakistani women adhere to such beliefs as "important" practices that ensure a healthy pregnancy, safe birthing, and a sound and smooth postpartum period. Hence, the temporary or permanent prohibition of sexual intercourse during pregnancy and the postpartum period should be seen in connection with the social construction of beliefs and practices surrounding infant care, practices that begin as early as the woman conceives the fetus. As soon as pregnancy is confirmed, avoidance of sexual contact is initiated by women so as to ensure that unnecessary complications are averted [33–36].

9.5.2 Birth and After Birth (Postpartum)

Birth and the postpartum period represent an ongoing transition phase of emerging new identities for the couple who have now become parents. Comprised of a complex combination of sense of loss and excitement of achievement, sexual and reproductive health may be an important issue during this transition period [37]. Birth is seen as the transition (both biological and psychological) from a woman to a mother. During this transition phase, a temporary decrease or increase in sexual interaction may occur. Sexual interaction, on one hand, may increase due to the return of sexual interest/arousal, and as a way to strengthen much needed emotional ties between the partners during this phase [38, 39]. Yet another perspective is that the body-response

(biological conditions after birth) and the fears related to birth pollution (psychological conditions after birth) may lead to sexual dysfunction or decreased sexual activity. The reasons for sexual dysfunction may be many, and besides the physical and psychological discomfort, it may be associated with the social and cultural factors that cause discontinuity of sexual activities before and after birth. Marital adjustment, parental status, and relationship issues are just some of the sociocultural factors that diminish sexual engagement [33, 40]. In Asian societies, the fears discussed above typically remain significant after birth and during the postpartum as a part of the tradition of ensuring maternal and child health [37]. Specifically, cultural beliefs surrounding a medical condition play a vital role in restricting sexual activities during pregnancy, birth, and the postpartum.

9.6 Asian Culture and Sexual Health: Helping Those with Sexual Issues

This section focuses on the need for cultural sensitivity in the assessment and treatment of sexual issues in South Asian regions. As described above, the dynamics of sexual practices in the Asian subcontinent are quite different from the Western population, generating the need for culturally sensitive practices when dealing with sexual and reproductive issues in this population.

The contribution of culture is important in defining ideal, acceptable, normal/abnormal, and offensive sexual behavior. Most subcultures of this region sanction sexuality only within wedlock. Even the basis for marriage is diverse among different cultures. Unlike Western societies where marriage is based on mutual interest and love between the two individuals, in many subcultures of the Asian subcontinent, marriage is decided between two families, with the heterosexual couple consenting to it. In some instances, the consent of the woman is either not taken or her opinion is entirely ignored by the family. The union is often expected to be consummated during the first night following the wedding day. It is challenging to estimate the accurate prevalence of sexual problems in Asia, as most of the epidemiological literature regarding sexual issues is from Western nations. However, the first multinational comparison of sexual dysfunction reported the incidence of lack of interest

Box 9.4 Helping Those with Sexual Issues

- Dhat syndrome is a cultural bound syndrome brought on by fear of semen loss through nocturnal emissions, urine, and masturbation.
- Sexual practices in the Asian subcontinent differ from the West, requiring culturally sensitive practices when dealing with sexual and reproductive issues in this population.
- Understanding of the cultural myths and belief systems of South Asian clients would help healthcare practitioners tailor optimal treatment plans.

in sex, inability to reach orgasm, early ejaculation, lubrication difficulties, and erectile difficulties as higher in Asia than in any other part of the world [41]. This higher prevalence may partially be attributed to the abovementioned marriage practices and the way marriage is decided by others rather than the partners themselves.

Other sexual problems not observed in the Western world but relevant to specific cultures are referred to as culture-bound syndromes. Dhat is one such culturally bound syndrome that emerges from Asian countries. Dhat is characterized by "undue concerns about the debilitating effects of the passage of semen," also known as "semen loss"-related psychological distress. It is most prevalent in India but has been reported in other countries in the region, including Pakistan, Bangladesh, Nepal, Sri Lanka, China, Malaysia, and Indonesia.

Wig (1960) coined the term "Dhat syndrome," characterized by vague somatic symptoms of fatigue, weakness, anxiety, loss of appetite, and guilt attributed to semen loss through nocturnal emissions, urine, and masturbation, even though there may be no evidence of loss of semen. However, the *fear* of loss of even a single drop of semen can trigger somatic symptoms and the manifestation of hypochondriacal, anxiety, and depressive symptoms which, together, take the form of Dhat syndrome. The profile of the individual affected by Dhat syndrome is typically a young, married villager having a conservative attitude towards sex. Dhat syndrome has high comorbidity with depression, anxiety, and sexual dysfunction in South Asian cultures [42] (see Table 9.2).

The assessment and management of Dhat syndrome requires cultural sensitivity and understanding by health care practitioners. Dhat does not have specific diagnostic criteria but can be assessed with the *Dhat Syndrome Symptom Checklist* developed in Pakistan [46]. Patients with these symptoms most often visit "hakims" and "vaids" (traditional healers) for treatment involving herbs, general counseling, and

Table 9.2 Summary of presenting complaints by patients with Dhat syndrome

Physical complaints	Psychological complaints	Sexual complaints
Multiple body ache	Depression	Erectile dysfunction
Physical weakness	Anxiety	Premature ejaculation
Excessive salivation	Stress	Impotence
Loss of weight	Guilt	Genital itching
Fatigue	Neuroticism	Loss of libido
Listlessness	Delusional disorder	Prominence of genital veins
Burning micturition	Somatoform	Concern regarding sex
Increased frequency of micturition	Hypochondriasis	Thinness of semen
Difficulty in micturition	Breathlessness	Shrinking of penis
Weakness in legs	Disturbed sleep	Decreased desire for sex
Muscle tension	Restlessness	Enlarged testes
Burning sensation in urine	Lack of interest in work	Smallness of testes
Gastric disturbances	Nervousness	Other sexual dysfunctions
Shallow eyes	Suicidal thoughts	
Dryness of mouth	Palpitations	
Constipation	Loss of appetite	
	Poor Memory	

Source: Arafat [43], Deb and Balhara [44], and Grover et al. [45]

dietary intervention. Modern medications do not appear effective in managing Dhat syndrome, but the use of psychoeducation and culturally informed cognitive behavioral therapy (CBT), along with active listening, relaxation exercises, and placebo are generally helpful [47]. As Dhat syndrome is usually manifested with anxiety and depression, anxiolytics and antidepressants may also be used. In case of comorbid sexual dysfunction, sex education and pro-sexual medications can be effective.

9.7 Culturally Sensitive Assessment and Treatment of Sexual Problems

It is first important to realize that depending on cultural beliefs and gender boundaries, discussions about sexuality by men and women, even within clinical contexts, may be very limited in the Asian subcontinent. For example, due to cultural restrictions, women are reluctant to talk about their sexual issues, and as a result little is known about the kinds of problems they face and how they deal with them. In rural Punjab, for example, female sexual health issues are private matters and only the close women in the family are permitted to discuss such issues or give guidance regarding them (even regarding such issues as fear of childlessness or infant mortality disease) [33].

Even when issues of sexuality surface, for example, within clinical contexts, they need to be viewed through an appropriate cultural lens. Although the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has universal applicability for the diagnoses of sexual disorders, a good number of the sexual issues in the South Asian region may fall into the category of "Not Otherwise Specified" [48]. Assessing the sexual issues of individuals in the light of the culture is essential, as what might be seen as abnormal in one culture might be an acceptable and normative in another culture. Such differences reiterate the importance of culturally sensitive practice in understanding, assessing, and treating sexual disorders. Culture serves as a lens for clinicians to view and interpret symptoms of the individual within the broader social framework.

Case Study 2

A young unmarried Indian male presents with the symptoms of physical weakness, onset of acne, weakening eye sight, and fear of inability to sexually satisfy his wife after the marriage. While discussing the symptoms, he mentions masturbation as the key concern leading to all of the abovementioned symptoms. If such a case is presented to a culturally insensitive therapist trained with the traditional Western mindset, the therapist might utilize his sessions explaining that masturbation causes no such harm to the body and sexual performance for the individual.

However, this approach might not be very helpful for the client from a culture where these symptoms are perceived as the side effects of masturbation and represent a belief that is deeply embedded through cultural experience. Moreover, if the client is Muslim, Islam prohibits sexual activity outside wedlock, with masturbation considered a sinful act which, if performed, might bring feelings of guilt and disgust.

A culturally sensitive therapist might inquire about the meaning the client attaches to the symptoms and his fears. Rather than challenging his belief, the therapist should refer the client to a physician for remediation of the acne and investigation of the symptom of physical weakness (if not explained psychologically). Furthermore, the therapist should address the fears and anxiety of the client and provide information regarding his concerns about sexual performance after marriage.

With reference to the Asian subcontinent, culturally sensitive instruments to assess and diagnose sexual functioning are scarce. As a result, reliance on instruments developed and standardized in the West should be used with caution, as they represent typical functioning of Western men and women, which can lead to invalid conclusions regarding the Asian population. Also, in-depth interviewing is recommended, as reliance on paper-and-pencil instruments may overlook important and unique cultural differences. Therefore, healthcare providers and practitioners need not only to develop culturally sensitive interviewing skills, but also to understand issues relating to sexuality through informal assessment, with an emphasis on the broader cultural and societal values being of utmost importance.

In brief, we conclude that culturally sensitive assessment and treatment requires a deeper understanding of the context in which the client lives. Building awareness about the nature and causes of the problem in the broader ecological context, as well as assessment and understanding of the cultural myths and belief systems of South Asian clients, would help healthcare practitioners tailor the treatment plan accordingly. Such a plan would entail deeper knowledge and emphasis on the client's own "explanatory models" so as to make the management plan more meaningful to the client.

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10 Western, Asian, and Middle Eastern Societies' Cultural Attitudes and Barriers Impacting the Management of Sexual Health Care

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10.1 Introduction

There has been noticeable development within the field of human sexuality research in recent years regarding the impact of cultural variation on sexuality and health. Still, the management of sexual healthcare (i.e., sexual history taking, sexually transmitted infections (STIs), and sexual dysfunctions (SDs)) remains a marginalized topic throughout much of the world. Having an understanding of this issue, and its impact on patients, is essential, since discussions of sexually-related topics are often taboo within both mainstream- and sub-populations, both in East and West societies [1–3]. Cultural barriers within these societies prevent patients and providers from communicating effectively, or with ease, with one another, thus highlighting the need for sexuality-related communication training for sexual healthcare providers [4, 5]. The purpose of this chapter is to examine the sexual healthcare management offered to patients by both Asian-American and Iranian-American physicians through the lens of their cultural beliefs and attitudes, which may well inhibit the open discussion and provision of sexual healthcare. We base our analysis on previously published literature on this topic, a survey conducted with Iranian-American physicians practicing in California, and case studies of physicians and patients from various cultural backgrounds.

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Sexual health is increasingly recognized as encompassing physical, mental, and emotional well-being, in relation to sexuality and sexual relationships, with the important corollary that sexual relations should be free from coercion [6]. The World Health Organization (WHO) notes: "Practicing physicians may hold different cultural backgrounds. These differences may limit addressing certain aspects of sexual healthcare and interventions, because they are not culturally acceptable or appropriate. Sexual health varies across different cultures. However, sexual healthcare must be inclusive of the diversity of needs among individuals across their life spans, settings, and circumstances…". To date, the failure of health communities to recognize sexually-related issues as a primary diagnosis and as an important public health concern may have contributed significantly to the sudden global rise of sexually transmitted infections (STIs) and sexual dysfunctions (SDs). Physicians' proactivity in obtaining a sexual history from patients is essential to improving patients' sexual health and survival rate [1, 5, 7]. The perspectives of patients about the adequacy and quality of sexual healthcare are a neglected area of the research literature, particularly among sub-population patient groups in the USA.

10.1.1 Sexual Health in Western Societies

The Centers for Disease Control and Prevention (CDC) suggests that, since 2014, nearly 2.3 million new cases of chlamydia, gonorrhea, and syphilis were diagnosed in the USA [8]. This increase is significant compared to Europe and Australia [9]. Key affected populations in Western and Central Europe, USA, and Canada include men who have sex with men (MSM). In the USA, MSM account for 67% of all new HIV infections, despite representing only 4% of the population [10]. Among ethnic minorities, the increase was 20.6%, while the white population showed an 18% decline [10]. Canada reported 54% of all new infections occurring in 2014 were among the MSM population [11].

In 2015, in Western and Central Europe, the prevalence among MSM was highest in France and Romania (18%) [12]. Among approximately one million transgender adults in the USA, about 28% of females were living with HIV. More than 56% of African-American transgender women were HIV positive [8]. Yet, despite the severe need for diagnosis and treatment among these populations, marginalization has, for example, led many transgender people to avoid visits to health services. People who inject drugs (PWID) accounted for 15% of all new HIV infections across the region [12]. Such statistics indicate that problems regarding sexuality and health are growing rather than diminishing, even in highly developed Western countries.

While most countries in Western and Central Europe and North America adopt combination HIV prevention strategies such as condom availability and use [8, 12], new innovations in antiviral medication [8], and providing HIV education in schools [13], fewer than 50% of US medical schools have more than 2 h of sexual medicine instruction and/or training in managing sexual problems. Many schools avoid the topic of sex altogether [14]. In the UK nearly all (94%) of Ob/Gyns [15] and in the

USA less than 50% [1, 16] of Ob/Gyns know less than half of their patients' sexual concerns and are unaware of the prevalence of these issues in their practice. This result is due to the discomfort of Ob/Gyns, those most likely to render care related to sexual health. This discomfort significantly impedes adequate sexual health assessment and the management of sexual problems [17]. The level of discomfort may vary with cultural norms concerning gender interactions, as well as attitudes toward diverse sexualities and communication styles.

Studies have noted and expressed concern that sex-related healthcare is largely ignored by politicians, economists, religious leaders, education sectors, and policy makers [18]. In November 2018, according to *Foreign Policy* reports, US diplomats may soon be prohibited from using the phrases "sexual and reproductive health" and "comprehensive sexuality education" under a proposal floated to the Secretary of State and other conservative political appointees. This tack is being taken, rather than the gathering of information and listening to the advice of experts, on issues related to sexual health [19]. A decision to implement such a policy would cause direct and real harm to the sexual health and rights of individuals, families, and communities, and would undermine the prevention and treatment of HIV and likely increase maternal deaths and unwanted pregnancies. Similar reports suggest that between 2017 and 2018, CDC officials were instructed not to use terms such as "transgender," "vulnerable," "entitlement," "diversity," "fetus," "evidence-based," and "science-based" in official documents in order to secure funding. Funding cuts to sexual and reproductive care, including for HIV, in Western and Central Europe and North America, have increased in recent years. *Foreign Policy* (2018) notes that "Proposed U.S. Cuts to AIDS Funding Could Cause Millions of Deaths," with the headline, "Cuts to sexual-health services imminent" [20]. Precisely at times when global sexual health issues are on the rise, some governments appear to deny, minimize, or ignore the issues, heightening a form of pervasive social sexual anxiety globally.

10.1.2 Sexual Health in Asian and Middle East Societies

Asian and Middle Eastern cultures take a highly restrictive view on sexual issues [2], as discussion of sex has always been and remains a taboo subject within those cultures [21, 22]. Not surprisingly, the practice of sexual medicine and/or sexual healthcare can be challenging in these regions. Asia has an estimated 151 million cases of STIs each year [23]. Within the Middle East and North Africa, the number of people having HIV/AIDS is estimated at half a million [24]. However, such numbers are likely underestimated due to the paucity of accurate statistics and the exclusion of some Middle Eastern countries due to lack of reporting [24, 25].

Of the 1.15 billion young adults (15–24 years) in the world, over 700 million live in Asia, including young men who have sex with men (YMSM). Generally, young adults (15–24 years) are poorly informed about protection from unwanted pregnancies and STIs, including HIV/AIDS. They are often reluctant to obtain sexual health services [26, 27]. China, for example, has experienced an increasing

epidemic of STIs/HIV [27], with HIV prevalence among MSM in China increasing to 8.0% in 2015 [28]. Others, such as female sex workers (FSW) [29], drug users, and migrant workers [30], as well as youth in general (2% globally), are recognized high risk groups for STIs [31, 32]. This increase is likely related to low HIV/STD knowledge [33], high rates of unprotected anal intercourse [34], perceived low risk of HIV infection, and fears of being stigmatized upon seeking treatment [35]. For example, more than half of Chinese women report feeling embarrassed consulting a physician regarding sexual problems, as they fear experiencing cultural prejudice or stigma [36]. For this same reason, few women in China seek sexual healthcare for very serious diseases such as cervical cancer (CC). Physicians too, are not appropriately prepared for dealing with these issues [36]. Chinese men generally do not discuss their sexual problems such as erectile dysfunction (ED) with their physicians, contrasting substantially with Western men who generally seek treatment for ED from their primary care providers [37]. In Southeast Asian countries, the topic of ED, with a prevalence rate of 20–33% [38, 39], is mostly ignored, due to physicians' low level of proactivity and their laissez-faire attitudes toward sexuality [40].

In the Middle East, there may be both beneficial and unfavorable links between HIV prevalence and traditional conservative Muslim practices, which may influence behaviors that affect HIV transmission [24]. Such practices include low alcohol use, which reduces risky sexual behaviors; male circumcision, which may reduce infection; cultural norms, beliefs, and practices; early marriage; and fears of stigma and discrimination against people with HIV/AIDS [41]. Other research reflects on physicians' lack of proactivity regarding sexual healthcare within this region, with reports suggesting that, for example, Iranian physicians are not well informed about HIV/AIDS and have negative attitudes toward these patients [42]. Both male and female Ob/Gyns in this region rarely ask female patients about sexuality, sexual practices, or problems [43, 44], and they typically rely on patients to initiate conversation related to sexual health [43]. In addition, cultural biases related to sexuality in the elderly population are common to this region, where older persons are generally viewed as asexual individuals [45].

Not surprisingly, one study reported that little is known about the knowledge, needs, attitudes, or practices of the sexual and reproductive health of Saudi women [22, 46]. As noted previously, discussion of sexual issues is a highly sensitive topic and is not part of the standard operating procedure among physicians or specialists such as Ob/Gyns in this region [47]. Barriers to adequate sexual healthcare treatment have included the lack of appropriate health services as well as limited education and communication about sexuality due to religious and cultural taboos, particularly where single unmarried women are concerned [48]. Furthermore, the high social and religious value placed on virginity in most Arab countries puts women at risk of stigma or negative reactions from health professionals if they do try to obtain contraceptive or sexual healthcare services or advice [24]. Women are at particular risk: they are infected with HIV at younger ages than men due to gender inequality [47] and yet have no possibility of referrals to specialists in countries

such as Lebanon [49]. Lack of training and the modesty that makes physicians reluctant to discuss problems are considered further barriers to sexual healthcare in these regions [50].

10.2 Summary of Studies Conducted on Iranian-American Physicians and Women

Here we report on two recently completed projects: a qualitative study on Iranian-American women's sexuality [3, 51] and a survey of Iranian-American physicians' management of their sexual healthcare practice [5, 52, 53].

In our qualitative study, we explored the sexual-selves of Iranian-American women, representing the first ever attempt to study this topic in these women. The results revealed many cultural factors that impacted Iranian-American women's sexual-selves. The fundamental categories that contributed to sexual-self formation included the institutionalized familial, cultural, religious, and traditional, as well as the interactive aspects of one social system on the other.

In the competition between the individual and culture are other power struggles – religion against religion, religion against culture; young against old; traditionalism against modernism; governments against the people; and poor against the rich, to name a few. These contexts do not exist independent of one another; rather they interact at some level, in some fashion, one with the other, and exert power in whatever way needed to maintain the current hegemonies. With respect to Iranian-American women, through socialization, they experience a profound imbalance of power operating between themselves and their culture. The power exerted from the patriarchal family structure, religion, and government to preserve these various institutions reaches such a magnitude that these women have little counter-power for developing their own individual sense of identity. When institutionalized power is exerted so heavily, the result is suppression. In such a suppressed condition, attempts to resist are often met with abandonment, punishment, or even execution [3, 51].

Regarding the survey, a self-administrated questionnaire was designed and sent to 1550 Iranian-American physicians practicing in California in order to study barriers and attitudes inhibiting the discussion and provision of sexual healthcare offered to patients. Physicians' characteristics are listed in Table 10.1, and some of the findings are summarized in Table 10.2. The key barriers [52] and attitudes [53] impacting management of sexual healthcare [5] among this population included embarrassment, cultural and religious stigmas, and lack of time and financial constraints. Our data revealed significant associations between physicians' gender, country of medical graduation, religion, birthplace, and age, in particular for females [53]. Clinical specialty was not significant. Our factor analysis suggested that Iranian-American physicians may hold complex cultural roles and value systems that potentially influence their approach to sexual history taking, which in turn may impact their management of sexual healthcare [5, 52, 53].

Table 10.1 Physicians' characteristics

N = 354	*n* (%)
Gender	
Male	203 (57.3%)
Female	132 (37.3%)
Missing	19 (5.4%)
Age	
30–39 years	36 (10.2%)
40–49 years	110 (31.1%)
50–59 years	71 (20.1%)
60–69 years	97 (27.4%)
70–89 years	15 (4.2%)
Missing	24 (7.1%)
Place of birth	
Iran	291 (82.2%)
Other	35 (9.9%)
Missing	28 (7.9%)
Country of medical education	
Iran	190 (53.8%)
USA	130 (36.8%)
Other	8 (2.3%)
Missing	25 (7.1%)
Religion of physician	
Muslim	192 (54.4%)
Jewish	77 (21.8%)
Other	64 (18.1%)
Missing	20 (5.7%)

Table 10.2 Factors impacting physicians' sexual healthcare

	Factors	Cronbach's alpha
Barriers to sexual healthcare	Physicians' embarrassment	0.91
	Culture and religion	0.87
	Time and financial constraint	0.87
Attitudes toward sexual healthcare	Patients gender	0.94
	Female sexuality	0.88
	Age and marital status	0.82
Management of sexual healthcare	Female sexual dysfunction	0.94
	History of sexual intercourse	0.93
	STIs and knowledge of disease	0.89
	Male sexual dysfunction	0.90

10.3 Illustrations Through Case Studies

In an attempt to illustrate the typical issues raised by physicians and patients, we have included two physician case studies and two patient case studies. These were obtained from an ongoing study in order to highlight sexual health management issues that could have implications for clinical practice. Each set of case studies (physician then patient) is first reported, followed by synthesis and interpretation.

10.3.1 Physician's Case Study I

The first physician represents an Asian-American perspective. The participant, a 35-year-old single "*Taiwanese-American*" resident neurologist, was born to immigrant Taiwanese parents in the USA and raised in Orange County, California. He considers himself an "*American holding Chinese background.*" He has chosen the American-Taiwanese identity for himself in order to "…*fit more comfortably with both cultures*…" He explained that "… *during medical school, there is no focus on a second-generation physician…dealing with home culture*…". He further stated that "…*obviously I have an easier time identifying and dealing with Americans than the Asian population…and then people who speak Mandarin*…". There were "*no discussions of sex*" in his family, and the topic was "*ignored.*" *Generally, sexuality and sexual health…was never discussed at my home. I can tell you culturally…how Taiwanese deal with sexuality, and…that it is just not mentioned or talked about.*"

Taiwan has a strong and comprehensive national health care system. "… *because there is a biased cultural inheritance that is there, I think this conversation will be more difficult to have in Taiwan…than in the US…for patients…potentially for physicians as well… probably there is lots of reluctance from patients' perspectives to be forthright about answering these questions in Taiwan rather than the US.*" Within the US system of healthcare, he observed that "… *in a short clinical visit, when we want to focus on issues that are impacting patients' health, in the ways that it is how physicians are traditionally trained to think about it…physiological context and not sexual*."

He is "*uncomfortable with*" sexuality-related questions "*unless it is a male patient*," and there is the appearance of erectile dysfunction. And then "…*it is a little bit more straightforward… I am very comfortable to talk about genital sensation since that is very important for us to assess, we do those assessments all the time. But for female arousal and/or stimulation, I don't typically ask about that… and I probably should more. I think for myself, it is kind of more difficult to characterize a female having erection…arousal… or not…*". He recognizes that he "…*should be more proactive*…", but that he is not. While sexual arousal is talked about to a considerable degree during his training as a physician, he is looking for "…*kind of hard and fast physical exam findings…so that he can decide on doing an intervention on the primary diagnosis*…".

He did not have a "*basis for comparison*" regarding sexuality-related training during medical school, but recalled reproductive care as part of his training curriculum. "…*If it is not about any form of disability or a life-threatening situation, it is not a high priority when I am assessing my patients*." He believes there is "*no emphasis on sexual health care*," and "*there will always going to be underrepresentative areas of studies in medicine*." "… *to give sexual health care in a medical school curriculum is a tough concept, especially with respect to women*." He attributes this to "…*probably a lack of evidence bases for female sexual health care in particular…because of the comfort level of patients…and physicians' interest… of not wanting to offend patients*."

Regarding STIs, he believes that "*I don't think patients necessarily …especially women go to the doctor to discuss sexual health issues…I think that is also an issue… that has to be a part of medicine and unfortunately is not.*" STI testing is considered an easier assessment to make because it is more often a male complaint; and next to that, is asking about male patients' erectile dysfunction. "…*because… not to say that female sexual dysfunction isn't necessarily as prevalent…but there is a focus on men's sexuality for whatever reason.*" Due to "his *own inherent bias*" he believes that medical schools do not need to spend more time on sexual training. "*Sexual health is very important, but it may not be at the forefront of the issues that patients are facing on a daily basis. Sexuality probably does not get the amount of attention that it deserves. We have limited time and resources…focus on …diet, preventive medicine…no smoking…diabetes… are more important.*"

He believes that the burden is on patients to step forward with their concerns and ask for treatment. "*I am not sure if more time can be spent on that. Honestly…there is no extra time to be spent on 'these sort of things' in medicine in general. Other health issues are holding top priority. So, if you are asking me, can the medical system be better about this…yes… I can see… introducing sexual healthcare as a separate specialty on its own in the field of medicine...*".

10.3.2 Physician's Case Study II

The second case study concerns a neurology specialist in northern California who has more than 22 years of diverse clinical and medical experiences in psychiatry and neurology. He received his medical degree in Iran and moved to the USA about 25 years ago. He is single, has a strong religious belief system, and holds a moderate level of connection to his culture of origin and family members. Discussion about sex and sexuality was not permitted at home. He did not recall having any formal or informal sex education growing up in Iran. At medical school, the focus was on reproductive care.

He stated: "*Usually, for both patients and doctors, taking care of their primary diagnosis is more important than anything related to their sexuality*." "…*culturally, sex and sexual relationships, is not a topic that is easily opened and talked about. It is up to the physicians to pay more attention to this issue and to initiate sexually-related discussion with patients, and not wait for patients to bring it up.*" For him, gender alignment makes it easier to talk about sexual issues. "…*Naturally, the other issue for me has been the gender of my patients…Uhmm…I have seen this myself….*"

Due to a "*certain level of modesty and sexuality taboo in Middle Eastern culture, physicians are less proactive than Western culture… Even the male patients have difficulty expressing their sexual difficulties in front of their wives. Among physicians that feel comfortable to bring up the topic of sexuality with their patients, usually the conversation is brief and includes questions such as "by the way, how is your sexual life?" Do you experience any discomfort in that area?*" and a quick "*no*" answer from patient ends the discussion. "…*while there are some existing questionnaires about patients' quality of life, these questionnaires include limited questions*

about their sexuality. There is ultimately no in-depth or significant communication, talk, or discussion about sex with patients. "*But, from what I hear from my patients, primary care physicians too are not proactive in this area either.*" Training in sexuality during medical school was insignificant: "*I don't recall any significant discussion about sexuality, even though sexuality is an important area of quality of life.*" Another challenge for him has been the age of his patients; he was shocked when an 80-year-old patient told him his girlfriend was asking for Viagra.

The existing medical curriculum, he states, does not include sexuality as a significant topic of training. "*These curriculums are given to us from the top officials, and depends on physicians' specialty. So, sexual ideas need to become a part of each curriculum*, and *that curriculum evolvement has to do with the patients' demand… for example, consider HIV… there was no written curriculum until patients' demand for HIV treatment became significant..., once a demand is provided, it shapes into a whole new issue… the pharmaceutical companies do step in and add to the level of education needed, and during training, once they notice a gap, which usually there is high level of discussion about it, it becomes a part of curriculum from the top.*

For sexuality, I don't see among my patients stepping forward demanding treatment for a form of sexually related issue…"

Another aspect to consider "*… is the need for medications that enhance libido that apply both to male and female patients, or the enhancement of sexual relationship…then it is easier for us to approach (the) patient and let them know… there is such a medication. The pharmaceutical companies, may consider promoting related medications for treatment of both genders.*" He noted that physician's taking the initiative is likely to be very limited "*… imagine if I ask her about her sex life…I find it to be inappropriate to do so…I myself, at the age 50, have seen my own GP where he has never asked me about my sexuality or any related issues.*" He further stated that cultural evaluation was needed and talked about the importance of designing comparative methodologies to determine how patient and physician gender alignment impacts communication. "*Yes, it is more difficult to speak to non-American patients about 'it'.*" "*Usually, patients who are not American, they ask for a later private meeting, and it is during that time that they bring up sexually-related issues. This is because often there are family members present with the patient…*"

He believes that when physicians are open to asking questions "*we can identify if there is a problem and find a way to address the problem, and offer a plan of care.*" "*I believe this issue has been ignored… the need for education of physicians during their course of schooling and training, plus attending continuing education conferences, all do have a positive role in this situation. There is a need to educate people and it can be done through movies, TV programs, media which can normalize various aspects of sexuality. We need higher trainings for physicians and higher level of demand from patients. Ultimately, this falls on research, so that it is shown via evidence that there is a need for such curriculum for sexual health care.*" He concluded: "*For the inclusion of education and training in medical school curriculum…There is no significant emphasis on sexuality and sexually related diseases in medical schools, primarily because it is not openly talked about.*"

10.3.3 Synthesis and Key Points Regarding the Case Studies with Physicians

Both physicians' narratives supported their focus on reproductive care as their primary area of sexual health concerns. All other patient concerns, including sexual attitudes, behaviors, discomfort, or difficulties, were secondary. The views expressed by these two physicians further supported the results from our survey of Iranian-American physicians [5, 52, 53] which indicated that physician priorities were on physical diagnosis, assessment, and intervention rather than sexual healthcare. Their comments reiterate some of the challenges to sexual healthcare, supported by our previously published research, including:

- Lack of comfort talking about sex, attributed to physicians' culture of origin and training.
- Lack of physician and patient gender alignment during clinical examination, which decreases the comfort level of both.
- Patient's reluctance to ask about sexual healthcare and/or lack of physician's proactivity.
- Minimal emphasis on training about sexuality and sexual healthcare in medical school.
- Physician bias toward the elderly, believing they were no longer sexually active.
- Physicians' practice specialty, which provides no strong imperative to be proactive regarding sexual healthcare.
- Physicians' biases related to culturally shaped beliefs, i.e., gender roles, religion, marginalization, etc.

10.4 Case Studies of Patients' Perspectives of Sexuality and Sexual Health Care

Sexual issues and experiences of subcultures of women who are Asian-American [2] or Iranian-American [5], whether at home or in the host culture, have been noticeably overlooked in medicine and research. The lack of descriptive baseline information on women's sexual healthcare in such subcultures underscores the urgent need for narrative data that shed light on social and psychological issues relevant to their sexual healthcare. Here, we provide examples of such narratives through two patient case studies.

10.4.1 Patient Case Study I

Ginger is a 35-year-old Japanese-American single woman who is a full-time massage therapist working for herself and living with her parents. She was born in Japan and her family migrated to Los Angeles at the age of five. Currently,

she is in a secret though uncertain relationship for the past 8 years, which she characterizes as a "*big challenge.*" She struggles with her identity and sexuality. Ginger says that when growing up she did not recall ever having a conversation about sex at home or even among her friends. She essentially learned about her body at the health class during middle school which "*by far*" was the most education she received about sex. This helped her understand and accept her menstrual period… "…my mother told me *to keep my private area safe and untouched, even by myself...so I learned 'that' was the forbidden area in my body.*"

Her first sexual experience was at college. "*I loved my boyfriend, but of course our relationship was a secret one…and one day in his room, …he touched my forbidden area inappropriately…I was so fearful and nervous, that I did not feel anything and just wanted it to be over…*" With the help of friends, she learned about contraception, and their sexual activities continued. She did not experience orgasm, never recalling having a desire to have sex. She believed that she needed to provide sex in order to keep the relationship, and be ready every time her partner demanded sex. Eventually, the relationship was over, but the fear persisted that if her family ever knew that she was no longer a virgin, she would be a shame to the family. The pressure increased each time the conversation about getting married was raised. She blamed herself for not allowing herself to learn about sex when she had opportunities at school: "*…it is like from infancy, parents brainwash and shame us girls about our bodies...I can tell how this has happened to me and to my two other sisters…as my mother was playing with my siblings bodies during their infancy,…like showing them …this is your knee, this is your thigh, this is your tummy…and she would skip the genital area, as if it was non-existent, and had no name…*"

Her sex education was limited to television and books. She began to blame herself for not having the right orgasm, or not having the right body for sex, and she believed that something was wrong with the way she looked, including not having the right skills to be a desirable sexual woman. These beliefs prevented her from having other relationships. Later, when she learned to masturbate, she felt guilty and shameful every time and was confused about her experience of pleasure. She never talked to a physician or nurse about her forbidden area, even when she felt pain, burning, itching, and unusual discharges, but instead waited for the problem to go away on its own. "*How could I talk about my secret with a total stranger…I didn't want to see their negative judgements about me as a Japanese woman… I thought, if anything, my GP could have asked me more when I told him that I was having abdominal pain in my lower part during several visits…but he did not…so, I didn't see the need to bring it up …I don't have a gynecologist because I am not married…*" Altogether, her experiences with her "*forbidden area*" were a "*series of disappointments.*" To date, she continues to blame herself for "*having thousands of reasons for not being good enough for any man, and that she is shameful for being a woman altogether.*"

10.4.2 Patient Case Study II

Linda is a 30-year-old single woman who was born to a Spanish mother and an Iranian father in Los Angeles, and raised in different parts of the Middle East and Asia. She is currently living with her parents in Los Angeles. She owns her own business in fashion design and recently completed graduate school. Linda believes that with respect to her sexuality and sexual experiences, most of the time she feels very different from those around her, due to her multicultural life experiences. For example, when she is surrounded by her American friends, she feels different than when surrounded by her friends from Iran, Spain, India, or China. "*I had to formulate my own standards with both Eastern and Western cultures, and I even felt different with people with the same cultural background.*"

She never felt comfortable asking questions about sex of her family members "*… because culturally, it was considered taboo to talk about it on both sides, but more on my father's side.*" She felt very isolated growing up, so she developed her own standards around sexuality which eventually caused her to avoid sex. Currently, she still feels uncomfortable talking about sex, not only with her friends but also with her physician when she needs sexually-related medical care. Her fears of being judged and her shyness are still paramount. Her first sexual relationship at 23 was difficult, as she did not know how to handle the emotions related to sex.

At 13 as she attended a Catholic school, a class about sexuality was offered, but her parents refused to allow her attendance. Linda grew up in isolation and has not been able to have a solid relationship with a man because of the high level of *fear* and anxiety she experiences around sex. As a child Linda did not notice significant differences in the treatment of women in other cultures, and she believes that female sexuality has been used to judge and control women.

10.4.3 Synthesis and Key Points Regarding the Case Studies with Patients

The two women's narratives, along with our qualitative research, indicate that despite originating from different cultural backgrounds, both experienced similar negative and long-lasting emotional scars related to their sexual-selves.

Since American women tend to have a greater awareness about sex and feel freer to share their concerns with healthcare professionals, they are more likely to receive treatment. Western culture generally places fewer limitations on such sexual expression and concerns, the opposite holds for most Asian and Middle-Eastern women. For them, if disclosure is important for health reasons, they may disclose their concerns indirectly by complaining about physical pain such as headaches, abdominal pain, and fatigue, thereby often misleading physicians. They expect physicians to inquire about sexual healthcare, which seldom happened. Furthermore, if there is a concern about partnered sexual experiences (i.e., the nature of their sexual relationship, experiences, physical or emotional abuse, etc.), these concerns often go unaddressed. Such issues arise from the strong cultural restraints related to sexual healthcare in these women's social systems.

10.4.4 Implications and Recommendations for Public Health Practice and Future Research

Although our study analyzed the barriers and challenges to sexual healthcare in a sub-population of Iranian-American physicians, similar problems likely exist in other physician sub-populations and, to a lesser degree, in mainstream native US physicians. The role of culture in human sexuality is notable, since a person's sexual beliefs, attitudes, and behavior are strongly influenced by their culture of origin [2, 3]. From the perspective of ours and others' research on sexual healthcare, we make the following recommendations:

1. Sexual well-being is strongly associated with quality of life and hence, sexual health should be an integral part of holistic healthcare and routine clinical check-ups. Education policy makers should be encouraged to design effective sexual healthcare training and continuing education programs in which biases of practicing physicians are explored, identified, and addressed. Such programs might also include an evaluation of physicians' level of sensitivity and/or reluctance to discussing issues of sexuality, as such attitudes could limit proactivity in working with both mainstream and marginalized populations.
2. The diagnosis and treatment of sexual problems should be included as a legitimate health concern for greater discussion in medical schools, along with the necessary interpersonal skills needed to address such private issues with sensitivity. Medical education, particularly in emerging nations, needs to place greater emphasis on the benefits of STI screening in clinical practice. Worldwide, medical education needs to place greater emphasis on training about sexual diversity across the lifespan, gender, sexual minorities, and culture-of-origin, particularly where vulnerable populations are concerned, such as minority women.
3. Regarding the previous point, cultural sensitivities require that sexual health care involve more than just dispensing medication. Physicians, both GPs and specialists, particularly those with collective cultural backgrounds, could benefit from training programs that address cultural differences specifically related to sexual medicine. Non-castigating strategies need to be used to encourage physicians to participate in cultural studies on sexual healthcare such as those that we have conducted.
4. As part of their routine medical history taking, clinics could benefit from having standardized "sexual awareness questionnaires" available for patients and, based on this information, could engage with men and women more proactively with respect to their sexual healthcare needs. Additional research on other sub-populations of physicians and patients residing within Western societies needs to identify barriers and attitudes that affect sexual healthcare within those subcultures.
5. Finally, sexuality is influenced by social factors which may manifest in negative physical and psychological symptoms. Thus, counselors, clinical psychologists, sociologists, and anthropologists are often at the frontline of peoples' stories about their sexual lives, and therefore they play an important role in listening to, understanding, and identifying the kinds of problems that concern vulnerable sub-populations.

10.5 Summary of Major Points

In this chapter, we have discussed culture as a ubiquitous phenomenon that encompasses politics, religion, economy, and educational systems, all of which impact sexual health care. The barriers to sexual health care that result from culture are not shaped haphazardly. Rather, governments and organized religions often take an active role in shaping cultural attitudes and, in many instances, attempt to control the populace/constituents by dictating what is permissible and acceptable sexually. Being a powerful drive, sex can be a strong threat to those who seek to control the lives of others. Yet, such controls are often needless and sometimes even counterproductive in helping people establish healthy sexual practices. Most people's sexual stories focus on their internal struggles—pain, fear, guilt, shame, sinfulness, and secrets—that result from the strong cultural do's and don'ts that have been imposed upon them.

Progress will best be made through a collaborative approach, supported by the public health community, healthcare systems, religious leaders, and government and policy makers. Physicians and mental health professionals need to take the lead in refuting and challenging what might be labeled "appropriate laws and policies," if those policies do not truly address the best health interests of patients. All healthcare providers share in the responsibility of destigmatizing sex as a taboo topic and of breaking the unhealthy and sometimes harmful cycle of undue control over people's sexualities. Clearly, the education process needs to encourage health professionals to challenge their own assumptions and biases about sexual health and sexualities, and to examine how cultural and political forces shape actions or inactions in the management of sexual health.

In Box 10.1, we provide a list of organizations that include information and resources on sexual health. These organizations track statistics related to STIs and some also track policies related to sex education, birth control, and STI prevention and treatment in the USA, Canada, Australia, the UK, Iran, and Asia. These resources underscore the importance of knowledge about STIs and their current management protocols, as well as clinical practice related to other sexual issues so that patients feel comfortable in discussing concerns related to their sexual health.

Box 10.1 Resources and Guidelines on Sexual Health

Centers for Disease Control and Prevention (CDC):
https://www.cdc.gov/

World Health Organization: https://www.who.int/health-topics/

United Kingdom National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People—2010:
https://www.bashhguidelines.org/media/1081/2674.pdf

Canadian Guidelines on Sexually Transmitted Infections—Primary care and sexually transmitted infections:
https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexuallytransmitted-infections/canadian-guidelines/sexually-transmitted-infections/canadianguidelines-sexually-transmitted-infections-17.html

Sexual health medicine resources:
https://www.racp.edu.au/fellows/resources/sexual-health-medicine-resources

Australian STI Management Guidelines for use in Primary Care:
http://www.sti.guidelines.org.au/

Sexual Boundaries: Guidelines for doctors: http://www.medicalboard.gov.au/News/2011-10-28-Sexual-Boundaries-Guidelines-fordoctors-released.aspx

Country Information and Guidance Iran: Sexual Orientation and Gender Identity:
https://www.refworld.org/pdfid/547482914.pdf

East and South East Asian women's sexual health:
http://www.ohtn.on.ca/rapid-response-53-east-and-south-east-asian-womens-sexual-health/

Asian Health Plan:
https://www.countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Annualreports-and-plans/2017-0706-2017-18-CMHealth-Asian-Health-Plan-FINAL.pdf

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Latin American and Latina/Latino Issues in Sexual Health

11

Carmita H. N. Abdo

11.1 Introduction

According to the classification of the United Nations' Economic Commission for Latin America and the Caribbean [1], Latin America is made up of 20 countries and the Caribbean of 26 countries and dependent territories. Although these regions have different histories and languages, they share many similarities. Some countries have a common past of pre-Colombian civilizations; others share a past of colonization by Iberian countries (Spain and Portugal). In more recent times, many have developed strong economic, cultural, and geopolitical ties [2].

The region's common trends were highlighted in a recent overview of the demographic trends of Latin America since 1950: an abrupt decline of fertility in most countries, little change in nuptiality and celibacy levels, and unprecedented progress in educational attainment, together with worsening conditions of social inequality and poverty [3]. High levels of violence against women, homophobia [4], and unsafe abortion [5, 6] are also part of this cultural context. Despite a strongly *Machista* culture and religious influence, there is a high level of diversity of sexual patterns in the region, along with a parallel diversity of contexts of sexual risk, resulting in a wide range in the prevalence of HIV [7].

This chapter explores issues of sexual health in Latin America, with a focus on four broad topics: (1) Latin American medical education and sexual health; (2) pregnancy, contraceptive use, and attitudes toward gender among adolescents in Latin America; (3) sexual disorders and behaviors in Latin America; and (4) less-conventional sexual behavior and sexual identities. For some domains, Latin

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America shows similarity with other parts of the world; for others, the Latin influence appears responsible for certain trends and attitudes specific to the region.

11.2 Latin American Medical Education and Sexual Health

Worldwide, teaching hours for sexual education in medical courses are frequently insufficient to prepare students for their future roles in dealing with complex sexual issues [8]. This lack of preparation may be reflected in clinic consultations, where patients are often unwilling to discuss concerns related to sexuality with physicians [9–11]. A similar situation characterizes Latin America, as reported by 207 professors from 110 Brazilian medical schools who completed a semi-structured questionnaire about topics related to sexuality. Most respondents gave 6 h of lectures related to sexuality in the 3rd and 4th years of the medical curriculum. Gynecology (51.5%), urology (18%), and psychiatry (15%) most often included sexuality-related topics, with themes related mainly to sexually transmitted infections (STIs) such as HIV (62.4%), or anatomy and physiology (55.4%). About one quarter reported teaching courses with titles related to sexuality, with risky sexual practices and STIs (87.9%) and sexual dysfunction (75.9%) being the prevalent topics [12]. However, the curricula of most Latin American universities included few or no modules about sexual health in family planning, public health, gynecology, urology, or general medicine courses [13], indicating the need to better integrate information about sexuality into the Latin American medical school curriculum [14]. The strongly religious culture likely plays some role here, but the fact that in many developing nations, medical priorities are directed toward managing and preventing infectious and chronic diseases and dealing with general health, may be more relevant than cultural inhibition.

11.3 Pregnancy, Contraceptive Use, and Attitudes Toward Gender Among Adolescents in Latin America

11.3.1 Adolescent Pregnancy

Worldwide, approximately 16 million girls between the ages of 15 and 19, and two million girls under 15, become pregnant every year [15, 16]. Over a million births occur to girls under 16 in Africa each year, and over 300,000 are estimated for Latin America and the Caribbean [17]. In Brazil, approximately one in five women has her first child before the age of 20. In the past 10 years, the fecundity of adolescents between the ages of 15 and 19 fell by 18.6% [18].

Little progress has been made in reducing adolescent first births in Latin America. Adolescent girls in these countries continue to be at high risk for poor reproductive health and birthing before 20. Survey data from Bolivia, Colombia, Dominican Republic, Haiti, and Peru examined trends in the percentage of adolescents giving birth before age 20 and found that young motherhood continues to be a major

concern in these countries, with little or no progress over the past several decades [19]. Young motherhood not only puts the health of women and their children at risk and limits their educational and economic opportunities, but it also impacts more broadly on families, communities, and national development as a whole. Adolescent births continue to be concentrated among the poor and those living in rural areas. Future strategies need to strengthen legal frameworks for protecting those at risk of abuse and exploitation. Additionally, greater efforts need to be made to disaggregate adolescent pregnancy and sexual health data in order to better measure and ensure progress in the well-being of such vulnerable groups [19].

According to the Pan American Health Organization/World Health Organization (PAHO/WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNFPA), teenage pregnancy is estimated at 46 births per 1,000 girls. Adolescent pregnancy rates in Latin America and the Caribbean are the second highest in the world, estimated at 65.5 births per 1,000 girls between 15 and 19 years (surpassed only by sub-Saharan Africa) [20].

The Brazilian teenage pregnancy rate exceeds this average, estimated at 68.4 births per 1,000 adolescents in 2014 [21], despite a reduction from 83.6/1000 in 2000. Brazil currently occupies the fourth place in South America [20].

The proportion of live births for adolescent mothers is related to the United Nations Human Development Index (HDI)—such that as HDI decreases, the proportion of live births decreased. Lower HDI scores are associated with poor socioeconomic conditions, poor access to health services, and lack of contraceptive use, conditions which to some extent may be driven by cultural beliefs and differences [22]. In fact, the most important factors related to early pregnancy are poverty and the low level of schooling—often intertwined—with the pattern repeated across many less developed countries [17, 23]. Adolescent pregnancy in most cases is unplanned and thus should be treated as a public health problem due to its familial, emotional, and economic impact on the adolescent mother, the partner, and the child and their families, creating and perpetuating a cycle of need and social inequality in these countries [24]. Furthermore, consistent with the idea that teenage pregnancy is a public health concern, maternal and neonatal complications are higher in adolescent mothers, and include pregnancy-specific hypertensive disease, prematurity, and low birth weight [25]. Adolescent maternal death is most likely caused by hypertension, hemorrhage, and infection, the latter two being related to unsafe abortion, which is highly prevalent among adolescents [26].

11.3.2 Contraceptive Use

Teenage pregnancy and (lack of) contraceptive use are strongly linked. The primary strategy for prevention of early sexual initiation and pregnancy is the inclusion of the adolescent in health education and prevention programs that emphasize the use of condoms and contraceptives [27], with the encouragement of using double protection (condom plus hormonal method). Unfortunately, interpretable data on such usage have been lacking until recently. Analysis of Demographic and Health

Surveys contraceptive calendars are making a valuable contribution to monitoring trends in the sexual exposure, contraceptive use, and reproduction of single (often young) women in Latin America. During the 1990s, conception rates for young women in general increased in Latin America [28]. In turn, these rates decreased from the 2000s, due in part to increased contraceptive use.

11.3.3 Gender Equality, Sexual Behavior, and Communication About Sex Among Adolescents

Although understanding the relationship between attitudes about gender and adolescent sexuality has been recognized as a priority by the United Nations Population Fund and the World Health Organization [29, 30], in Latin America, until recently, few studies had focused on the *societal, interpersonal, and individual* factors related to this relationship [31–37]. DeMeyer et al. [33] conducted one of the first systematic investigations regarding the relationship between gender attitudes and the sexual behavior, experiences, and communication within a large sample of Latin American adolescents. At the societal level, these authors affirmed that Latino cultures are still strongly characterized by *machismo-marianismo* attitudes, which include the traditional gender ideals of male dominance and female submission [34–36]. Studies in the Caribbean and Ecuador indicate that these diverse social and cultural gender norms have led to different sexual behaviors among boys and girls [36, 37]. *Macho* male adolescents are expected to be heterosexual, have many sexual partners, and engage in higher sexual risk behavior than female adolescents, who are expected to be innocent and self-sacrificing, making them more vulnerable to negative sexual and reproductive health outcomes [31, 36, 37]. These traditional gender norms also create barriers for adolescent girls to enjoy sexual experiences [34, 36].

At an interpersonal level, a Latin American cultural background results in increased difficulty regarding sexual communication [38, 39]. To counter this problem, the Horizon project in Brazil has demonstrated that boys who participated in interventions that promoted gender equitable behavior communicated with their primary partners about a broader range of key HIV/STI-related topics [31]. At an individual level, men who held more equitable gender norms were found to engage in less sexual risk behavior [32]. Research from Brazil and Ecuador has further demonstrated that a positive attitude regarding gender equality is closely associated with sex that is more consensual, pleasant, and pleasurable among adolescents [32, 34, 37]. Finally, better contraceptive practices—including condom use at last sexual intercourse—are linked to gender equitable norms of young men [32]. Developing a positive attitude toward gender equality means breaking free from the typical male role as virile, promiscuous, and dominant, and from the female stereotype as innocent, submissive, and self-sacrificing [37, 40–42]. Such attitudes—at the interpersonal level—may thus open opportunities to discuss not only topics related to STI/HIV, as was demonstrated in the Brazilian study [31], but also topics concerning contraceptive use [33].

The difference between the interpersonal and individual effects regarding gender equality is illustrated by a study on sexual pleasure in adolescent girls in Ecuador [33], a country that ranks 88th (out of 189) on the UN's Gender Inequality Index.[1] At an individual level, adolescent girls feel equal to boys, but due to powerful cultural expectations, at the interpersonal level they may consider it inappropriate or impossible to take the initiative for having sex and thus for seeking sexual pleasure [34]. Interestingly, adolescents who considered religion important were less likely to have developed an extensive sexual life, but when they did become sexually active, they reported more positive experiences and mutual initiative to having sexual intercourse [33]. One means to effect change in adolescents' attitudes toward gender equality is through sex education programs. Unfortunately, sex education for adolescents is not part of the culture in most Latin American countries [43]. Yet the correlation between positive attitudes toward gender equality and communication about sex among adolescents prior to first intercourse suggests that sex education that includes gender transformative components could play a key role in the sexual health and well-being of adolescents who are yet in the formative stages of sexual development [44].

11.3.4 Section Summary

High rates of adolescent pregnancy, lack of contraceptive use, and lack of buy-in regarding the equality of the genders are typical of most Latin American countries. Such trends are likely the result of the strong opposing forces of a *machismo-marianismo* culture (which encourages sexual activity) and a strong religious culture that discourages open discussion/acceptance of certain aspects of sexuality, particularly with regard to pre/extramarital sex and contraception. Furthermore, the redefinition of social expectations imbued in young people and the possibility of experiencing sexuality unrelated to reproduction have meant that the occurrence of pregnancy represents lost opportunities for a sizable portion of youth in these countries [27]. As gender equality is not yet widely accepted in Latin America, whether or not adolescents come to embrace such attitudes will likely have significant impact on future sexual health practices, with the potential to have strong positive effects [33]. Specifically, further study of the relationship between attitudes toward gender equality and positive sexual experiences for adolescents in Latin America may have positive sexual and reproductive health outcomes, such as lowering unwanted teenage pregnancies, reducing sexual risk behaviors, and increasing sexual pleasure among Latin American adolescents.

[1] Most Latin American countries fall into the Medium or High Human Development Index categories, and have Gender Inequality Indexes lying between about the 80th to 115th ranks (out of 189 ranked countries based on 2017 data).

11.4 Sexual Disorders and Behaviors in Latin America

11.4.1 Male Sexual Dysfunction

Prevalence The first population-based study in three Latin American countries (Colombia, Ecuador, and Venezuela) reported similar prevalences of erectile dysfunction (ED) [45] across these countries despite substantial socioeconomic differences. Age-adjusted combined prevalence of minimal, moderate, and complete erectile dysfunction (ED) for all three countries was 53.4%, with 19.8% of men reporting moderate to complete ED. Age was strongly linked to ED: the prevalence of complete ED was markedly higher in men older than 79 (31.9%) and 70–79 years (17.2%) in comparison with men 40–49 years (<3%). Medical conditions such as hypertension, benign prostatic hyperplasia, and diabetes, as well as the use of medications to treat these conditions, were correlated with ED prevalence. Such findings corroborate American and European studies demonstrating that ED is fairly common, increases dramatically with age, and has multiple correlates, including some that are also risk factors for cardiovascular disease [45].

The fairly high prevalence of ED reported in the multinational study was further corroborated in a 2002 Brazilian study on 1,286 men from nine major cities which indicated a rate of ED at 46.2% [46]. Applying this rate to today's Brazilian population would mean that more than 25 million men 18 years or older have some degree of ED, and 11.3 million are estimated to have moderate to complete ED. Such estimates suggest the widespread nature of ED in Brazil and Latin countries and, given the relationship of ED to cardiovascular health, identify ED as both a common condition and a significant public health concern. Brazilian rates, however, are not all that different from those reported in two studies from the USA: The Massachusetts Male Aging Study (MMAS) [47], a survey of a random sample of 1,290 men 40–70 years old living in the cities and villages near Boston, Massachusetts, reported 52%; and a population-based survey of approximately 1,650 men 50–76 years old in a rural zone of New York State reported 46.3% [48]. Similar rates have been found in France, where 39% of men aged 18–70 years reported ED [49], and in Thailand, where 37.5% of 1,250 men aged 40–70 reported ED [50].

Dysfunctions other than ED also appear to have a fairly high prevalence. In Argentina, the first study on ED, premature ejaculation, and male hypoactive desire disorder—published in 2004—reported that, of 2,715 men responding to a questionnaire on sexual health, ED, low sexual desire, and ejaculatory disorders were reported at 41.7%, 33.8%, and 49.3%, respectively. However, not all these men felt burdened by their condition, as only 37.8% considered the problem as a "sexual difficulty" and only 13.7% had consulted a physician about the problem [51]. An important caveat to all these studies is that prevalence rates rely on self-report data and do not typically involve a clinical evaluation and diagnosis.

Demographic Risk Factors In the Brazilian study [46], as documented in other research [47, 50, 52], ED was age-dependent, even after controlling for other variables correlating with ED [46]. Education was inversely related to ED, consistent

with findings from the MMAS [53] that the age-adjusted risk of developing ED was greater among less educated men, with education often serving as a common proxy for socioeconomic status in population-based studies [46]. Also in the Brazilian survey, men reporting black race showed a higher prevalence of ED [46] in contrast with a study in four American cities showing that ED was not dependent on ethnic group membership [54]. Although Brazilian results regarding race/ethnicity persisted in a multivariable analysis controlling for covariates, a residual confounding effect of socioeconomic status could not be ruled out, as assessment of social characteristics was limited [46].

Comorbid Risk Factors Consistent with data from other countries, a number of conditions greatly affect the risk of ED. As reported elsewhere, ED is more prevalent in diabetic men, with estimates ranging from 35% to 75% [55–57]. The Brazilian study cited above found moderate to complete ED in 37% of men with diabetes [46]. Cardiovascular disease has also been associated with ED [58, 59], with Brazilian results showing an association between ED and a history of hypertension or depression, irrespective of age, and the presence of other ED risk factors [46]. Studies from Colombia, Ecuador, and Venezuela support these relationships [45], consistent with results from North America and elsewhere [47]. Specifically, a higher prevalence of complete ED was associated with hypertension, diabetes, and treatments for these conditions, [55, 57, 58] although, interestingly, one study found a stronger association between ED severity in patients with *treated* diabetes and hypertension than for the *untreated* medical condition, perhaps attributable to the severity of disease and/or iatrogenic effects. A quality-of-life analysis in Brazil on over 5,600 men aged 40+ has also confirmed that lower urinary tract issues are frequently associated with sexual problems [60]. As part of that study, the Aging Male's Symptom Scale (AMS) revealed high frequencies of many symptoms associated with aging, including moderate/severe nervousness, irritability, sleep problems, joint pain and muscular ache, physical exhaustion, depressive mood, excessive sweating, decreased morning erections, and decreased sexual desire/performance. This last symptom, along with seven other parameters that comprise the AMS, indicated that 13.3% of the men had suggestive "androgen deficiency in aging male" (ADAM) symptoms. Among those with moderate/severe AMS scores, ED was twice as likely compared with those having none/mild answers to the AMS [60]. Finally, the correlation between ED and psychological states such as depression has been well documented in Latin American countries, although the direction of causality is unspecified, most likely being bidirectional (i.e., ED may follow depression and depression may be a consequence of ED) [61, 62].

11.4.2 Female Sexual Dysfunction

The determination of prevalence of sexual dysfunction in women depends substantially on diagnostic criteria and definitions, characteristics of the population studied, and the time frame of the study. Therefore, design, implementation, and reporting of

epidemiological studies require standardization before reliable systematic reviews and meta-analyses can be carried out [63]. Nevertheless, several findings do consistently bear out that female sexual dysfunctions appear to be strongly associated with psychosocial problems and difficulties in marital relationships [64], with poor educational background and low socioeconomic status constituting strong risk factors [65]. Cardiovascular problems and diabetes are also common risk factors [66–68]. In several studies, associations between lack of sexual desire and advancing age have been found. Not surprisingly, pain has been negatively related to the frequency of sexual intercourse [7, 65, 69–71].

From a Latin American context, the Brazilian Study on Sexual Behavior allowed for the identification of sexual dysfunctions in a sample of women aged 18 years and older. The presence of at least one sexual dysfunction was found in almost half the sample [72]. However, information collected through self-report questionnaires, such as done in this survey, lacks diagnostic precision: respondents may have difficulty understanding the questions and although they may endorse symptoms typical of sexual dysfunctions, the extent to which those symptoms are a source of interpersonal and psychological distress is sometimes not assessed—a critical condition for a diagnostic outcome [72]. Table 11.1 shows the age distribution of sexual problems or difficulties based on this study, with the caveat that a valid diagnosis requires clinical evaluation. Interestingly, psychosocial/physical factors such as attitudes toward sex and aging, relationship variables, vaginal dryness, and cultural background have a greater impact on most aspects of sexual function in women than biological aspects associated with aging, such as the transition to perimenopause [73].

In surveys considering female sexual functioning, the role of demographic variables such as education and age has been inconsistent. Although many studies have shown an association between education level and female sexual dysfunction, and orgasmic ability in specific [65, 74–77], others report no relation [78], even regarding orgasm ability [79, 80]. Although further investigation is required, any relationship between education and orgasm ability could be explained by the fact that more educated women may be more knowledgeable about their bodies and sexual function, the result of having greater access to information about sex and general health [77].

Table 11.1 Presence of at least one sexual problem in Brazilian women (hypoactive sexual desire, lack of sexual interest, orgasmic difficult, or pain during sexual intercourse)

Age group (years)	Without sexual problem, *n* (%)	Any sexual problem, *n* (%)
18–25	173 (54.9)	142 (45.1)
26–40	277 (55.6)	221 (44.4)
≥41	170 (42.6)	229 (57.4)
No data	2 (28.6)	5 (71.4)
Total *n* (%)	622 (51.0)	597 (49.0)

Adapted from Abdo et al. [72]
$P < 0.001$

11.4.3 Middle-Aged Women and Sexual Dysfunction

Prevalence The sexual issues experienced by middle-aged women are often distinct from those of younger women, as the former are often transitioning through major life experiences, including menopause [81]. A widely distributed cross-sectional study assessing the prevalence of sexual dysfunction and associated risk factors among middle-aged Latin American women surveyed 7243 healthy women aged 40–59 years who used healthcare systems in 11 Latin American countries (Argentina, Bolivia, Colombia, Chile, Cuba, Ecuador, Panama, Peru, Dominican Republic, Uruguay, and Venezuela). Of these women, 74.4% were sexually active with their partners. Those who were sexually inactive (25.6%) were significantly older, less educated, less healthy, used less hormonal therapy, were less likely to be married, and were more likely to be postmenopausal [82], variables that generally constitute sexual dysfunction risk factors [72, 83, 84]. Within this group, 16.4% of male partners had sexual dysfunction as well (ED and/or premature ejaculation). The sexual activity rate significantly decreased with age [82]. Nevertheless, the rate of sexually active individuals was higher than rates reported for Europe and the USA: 34% of European women aged 40–80 years [85] and 38.4% of US women aged 57–64 years [86] reported being sexually inactive in the last 12 months previous of these studies.

The prevalence of sexual dysfunction (56.8%) in this Latin American study [82] was not too different from those found by others using the Female Sexual Function Index (FSFI) in Colombia (37.8%) [87], Iran (39%; 50–60 years) [88], and Greece (48.8%; 43 years on average) [89], yet lower than that found in Thailand (82.3%) for women aged 45–55 years [90]. There is, however, substantial variation in such numbers, even within Latin America. For example, a cohort of middle-aged Ecuadorian women reported an overall sexual dysfunction rate of 78.4%, with the prevalence of these disorders increasing with age [91]. Whether such differences reflect methodological inconsistencies or true differences across Latin populations is not clear. Sexual desire was the most compromised sexual domain in Latin American women [82], a finding consistent with many other studies worldwide [72, 92–96], and this condition was often associated with various psychological issues [82]. In contrast, the least affected domain was sexual satisfaction [82]. These results suggest that specific aspects of sexual functioning may be affected in middle-aged women (rather than sexual response/behavior as a whole) and stress the importance of individual perceptions when defining sexual dysfunction [89].

Risk Factors In the Latin American study, the primary risk factor for sexual dysfunction in middle-aged women was poor vaginal lubrication [82] associated with menopause and resulting in unpleasant sensations and pain, although the condition was not unique to menopausal women [97]. Protective factors against sexual dysfunction included higher educational level and access to paid healthcare systems (indirect indicators of socioeconomic level) [82]. Similar findings have been

Table 11.2 Logistic regression analysis of main risk factors for female sexual dysfunction

	OR (CI 95%)	*P* value
Erectile dysfunction of the sexual partner	7.6 (1.7–33.8)	0.007
Premature ejaculation of the sexual partner	5.8 (2.9–11.3)	0.0001
Being an antidepressant user	4.1 (1–15.7)	0.03
Be married	2.9 (1.5–5.7)	0.002
Having work outside the home	0.2 (0.1–0.5)	0.001
More than 12 years school education	0.3 (0.2–0.8)	0.01
More than 4 intercourses per month	0.3 (0.1–0.5)	0.0001
Having only one sexual partner	0.4 (0.2–0.8)	0.01
Attend church	0.5 (0.2–1.1)	NS

Adapted from Yánez et al. [91]
OR odds ratio, *CI* confidence intervals

described in specific Latin countries such as Brazil [72]. The partner also exerts an important influence over female sexuality, with male sexual dysfunction significantly increasing the risk for female sexual dysfunction [82]. This pattern was confirmed in the Ecuadorian study [91], which also identified male sexual dysfunction and antidepressant use as major risk factors for sexual dysfunction in women. However, having work outside the home, more than 12 years school education, having only one sexual partner, and having intercourse at least four times per month were associated with reduced risk (Table 11.2) [91].

Other country-specific studies on middle-aged women have generally found patterns similar to the larger Latin American study. For example, a pilot study of urban-living, middle-aged Paraguayan women found that lower sexual function was characterized by being menopausal, lower coital frequency, and increased partner age [98]. For Chilean women, the cessation of sexual activity largely coincided with menopause—around 46 years of age—and may be related to the high prevalence of menopausal complaints such as menstrual irregularity, mood changes, and hot flashes [99, 100]. One of these Chilean studies also found that many middle-aged women living with their partner were not having sex, attributed mainly to their lack of sexual desire/interest [99]. This observation suggests that, for many middle-aged Latin American women, the sexual component of the relationship is not a determining factor in marital or couple stability. In a Brazilian study, sexual dysfunction, reported by 46.2% of the women, was associated with general health issues such as osteoporosis, urinary incontinence, and surgical correction of the pelvic floor, as well as comfort/openness about talking about sex decreasing the risk [101]. A Peruvian study affirmed the general belief that impaired sexual function is associated with depression and increased menopausal symptoms, although as with most research explicating such relationships, the depression-impairment connection was correlational [102]. And a study of Colombian women 40–62 years of age concluded that age, level of education, lack of sexual partner, degree of satisfaction with emotional closeness with the partner, and adequate lubrication influence the desire and orgasm domains in a significant way [103].

11.4.4 Latin American Culture and Sexual Behavior

The understanding of the behavior peculiarities of a particular population is essential for planning the approach to and treatment of sexual difficulties in that population. This understanding was one of the main objectives of the Brazilian Sexual Life Study [104], a study unique in Latin America and representative of the region and culture. In this study, a self-administered, anonymous survey asking about sexual behavior, sexual dysfunction, relationship stability, and life habits was taken by 7,130 subjects (54.6% men and 45.4% women), 18 years old and above, in 17 major Brazilian cities. 96.1% of women and 96.0% of men considered sex important/very important to the couple's harmony. Factors that contributed to sexual performance and satisfaction included: physical attraction to the partner (73.5% of men; 68.2% of women); tranquility and enough time for sex (69.5% and 66.5%, respectively); intimacy and mood (63.9% and 70.5%, respectively), affection and sentiment (62.3% and 77.2%, respectively); and relationship commitment (28.6% and 40.1%). Factors interfering with sex included: fatigue (57.3% of women and 50.1% of men); routine (34.3% and 28.1%, respectively), inadequate time for sex (26.2% and 19.4%, respectively), and anxiety (21.4% and 24.9%). 69.3% of women and 67.3% of men responded that sex occurred spontaneously; the remaining respondents reported partial/total planning. In this sample, sexual activity was frequent (2–3 times per week) and most often without planning (2/3 of the responders). Both men and women showed interest in having twice as much sex as their current level [104]. Obviously, general and sexual health present major deterrents to sexual activity. One large Brazilian study found that women with AIDS were characterized by low levels of sexual activity as well as the inability to maintain sexual arousal through to the end sex. Men with AIDS had greater difficulty becoming sexually aroused: they had less sexual desire and required more stimulation [105].

11.4.5 Section Summary

In Latin America, the occurrence and risk factors associated with men's sexual dysfunction—and more specifically ED—are not too different from those reported worldwide. Nevertheless, given the fairly high self-reported prevalence of ED in the general population in Latin American countries, such rates may be indicative of much larger health problems within these populations, as ED is often a comorbid condition of serious chronic diseases and conditions. Understanding such risk factors for ED may help health professionals not only in the individual assessment of patients with ED or in patients presenting with ED, but may prompt investigation of potential health-debilitating comorbidities such as diabetes and cardiovascular disease.

As indicated both by broad-based Latin American studies and country-specific studies, sexual problems in women (and middle-aged women in particular) share common features with women's sexuality in other cultures, yet exhibit several

culturally specific patterns as well. Women's sexual activity in Latin America appears to be highly sensitive to age, menopause, and lubrication, thus suggesting that for some women their activity may be related more to reproduction than to sexual pleasure. However, in identifying these simple risk factors, health professionals can intervene with inexpensive options, thereby improving the sexual capacity and interest for these women. Yet aspects of the sexual relationship, including the culturally endorsed *marianismo* attitude, likely position women's sexuality and pleasure subordinate to men's. Educational campaigns for middle-aged women may help challenge the mythology that sexuality is only for young people [103] and, further, including men in educational activities could help sensitize them toward women's experiences and feelings. Indeed, given that education level is consistently identified as a risk factor for sexual problems in women, as the overall investment in education continues to rise and the populace becomes better educated, there will likely be an overall positive impact on women's sexuality—and specifically middle-aged women's sexuality—across regions of Latin America [106].

Unfortunately, many Latin American countries suffer from unfavorable socioeconomic conditions, meaning that many populations have little or no access to basic health care, much less sexual health care in this region of the world, a situation that has major ramifications for the spread of STIs/HIV/AIDS. Furthermore, the increasing Latin American interest in sexual behavior—as well as the sexualitzation of youth worldwide—has not been associated with an equal number of studies and the appreciation of epidemiological data which, all in all, represent invaluable tools for the development of strategies and the allocation of adequate resources necessary for providing assistance for these populations. Furthermore, the rarity of sex education programs has forfeited the opportunity to educate youth and adults about sexual health and gender equality, both of which have the potential to mitigate issues related to sexual victimization, adolescent pregnancy, and sexual satisfaction and dysfunction. Fortunately, in the larger metropolitan areas of Latin America, these negative realities are less prevalent, with more positive attitudes beginning to spread to surrounding locales.

11.5 Less Traditional Sexual Behaviors and Sexual Identities

11.5.1 Unconventional Sexual Behavior, Paraphilias, and Paraphilic Disorders

In the most recent version of the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), paraphilia is defined as any "intense and persistent interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners" [107]. Paraphilia per se is not considered a disorder, but rather is related to sexual thoughts or behaviors that deviate from the social norm. In order to establish a diagnosis of a paraphilic disorder, these deviated thoughts and behaviors must cause distress or impairment to the individual or harm to others, and this distress should have lasted for a stable period of time (6 months) [107]. In contrast, so-called conventional sexual behaviors involve sexual

Table 11.3 Individuals who reported at least one type of unconventional sexual behavior throughout life in a Brazilian population

Sexual behavior	*N* (%)
Fetishism	778 (13.4)
Voyeurism	754 (13.0)
Incest practice	649 (11.3)
Sexual activity involving three people	622 (10.9)
Exhibitionism	535 (9.3)
Sadomasochism	523 (9.0)
Group sex	443 (7.7)
Having sex in exchange for money	274 (4.8)
Zoophilia	181 (3.2)
Exchange sexual partners (swinging)	174 (3.1)

Adapted from Oliveira Jr and Abdo [111]

intercourse between living adults, whose aim is to provide pleasure and/or to procreate. Unconventional sexual behaviors are represented by various preferences regarding one's sexual object, partner's age, or nature of sexual activity. When such sexual behaviors occur frequently and cause clinically significant distress or disability, they are sometimes classified as paraphilic disorders [108].

Contrary to expectation and labeling, unconventional sexual behaviors are not so rare in the general population. According to the US National Health and Social Life Study, 46% of young men and 28% of older men admit that group sex is an attractive idea, although these rates are lower both among young (9%) and older women (5%) [109]. The large cross-sectional Brazilian Sexual Life Study [110] attempted to characterize sociodemographic, physical, mental, and sexual health parameters of individuals that currently practice or have practiced one or more unconventional sexual behaviors throughout their lives. The most frequently reported unconventional behaviors were fetishism and voyeurism; the least reported activities were sex with animals (zoophilia) and exchanging sexual partners (swinging) (see Table 11.3) [111]. Possible overlap occurs in these categories, that is, the same people may be involved in multiple unconventional sexual behaviors.

As noted in the Table 11.3, the Brazilian study suggests that the prevalence of unconventional sexual behaviors was as high as 13% in the general population, although this percentage, because it was based on self-report, may actually underestimate the true rate. Furthermore, the prevalence was higher in men than women, and was associated with lower socioeconomic status, psychiatric disorders, and the presence of STIs [111]. Additionally, those engaging in these behaviors exhibited many of the negative mental and sexual health parameters typical of paraphilic disorders and sexual compulsion, including alcohol abuse, impulse control difficulties, and failure in the sexual response cycle. Further study needs to determine whether or not unconventional sexual behaviors present a pathway to paraphilic or other psychiatric disorders.

11.5.2 Transgender People

According to DSM-5, "*transgender* refers to the broad spectrum of individuals who transiently or persistently identify with a gender different from their natal gender,"

while *transsexual* "denotes an individual who seeks, or has undergone, a social transition from male to female or female to male, which in many, but not all, cases also involves a somatic transition by cross-sex hormone treatment and genital surgery (sex reassignment surgery)" [107]. *Gender dysphoria* is the distress associated with incongruence between the sex assigned at birth and the gender identity. The cause of this incongruence is presumed to involve a complex interaction among biological, social, and cultural factors [107]. In addition to the transgender and transsexual terms, *travesti* is a culturally specific gender identity term for Brazilians. *Travestis* are Trans people who were designated as male at birth but affirm a female gender performance and bodily form, although they typically do not undergo neovaginoplasty. Their gender identity varies: most identify as male, some identify as women, and others simply identify as *travesti* [112].

In its current framework, the DSM-5 emphasizes dissatisfaction with one's gender (gender dysphoria) rather than the pathologization of transgender identities. Consistent with this general trend, the ICD-11 has actually removed this condition from the list of mental disorders [113]. According to these reframed paradigms, Brazilian policy has been widened, providing an integral care at primary and secondary levels of attention [114]. Considering both the implementation of this policy and its ability to respond to the needs of the transgender and gender diversity community, its formulation is incomplete and still considered a work in progress [115].

Studies about transgender people in Brazil have shown that trans-specific healthcare services do not provide integral healthcare and, therefore, do not fulfill the needs of transgenders who are not seeking gender affirming surgery [116, 117]. Transgender people suffer from discrimination and difficulties in accessing healthcare [118, 119]. As a consequence, they may avoid seeking healthcare due to the difficulty in expressing their needs to untrained health professionals [114]. This same scenario occurs in Argentina [120]. In contrast, in 2008, Cuba's minister of public health signed into law an act that assured complete coverage for Cubans seeking sexual reassignment surgeries (also known as gender confirmation surgeries), the first of any country in Latin America to do so. Ten years later, Cuba is celebrated as having one of the most open and inclusive LGBTQ public health and education programs in the Americas [121].

Health professionals are generally unprepared to talk about gender and sexuality with their patients [12], an attitude that can cause incorrect diagnoses and implementation of potentially harmful medical treatments [114]. Transgender activists and global health partners have collaborated to develop new tools and guidance for assessing and addressing HIV and other health needs within transgender populations. While the needs of this group have only recently received attention, global, regional, and other technical guidance documents are under development to address these gaps. Regional blueprints for comprehensive care for transgender people in Latin America and the Caribbean have been available since 2013 [122].

During the development of the Blueprint for the Provision of Comprehensive Care for Trans Persons and Their Communities in Latin America and the Caribbean [123], a profound lack of knowledge about the characteristics and needs of the transgender population was noted in all Latin America and Caribbean countries. Major

gaps include: [1] prevalence and demographic data (age, area of residence, ethnicity, education, religious affiliation, occupation) of the transgender population of the region; [2] comprehensive and systematic epidemiology related to health issues and problems; [3] prevalence of risk behaviors; [4] predictors of risk and resilience (the ability to assume flexibility with extreme situations and overcome them); [5] effective prevention of health issues/complications through interventions; [6] access, supply, and use of appropriate health care services; and [7] mapping of structural risk factors and effective ways of dealing with them [123]. Healthcare professionals in Latin America are being urged to receive training in transgender and gender diversity community counseling and in psychotherapy and hormonal and surgical care, and to promote awareness campaigns that encourage the use of social names and the correct pronouns. Such actions are already under way in Brazil [124].

11.5.3 Section Summary

Research about unconventional sexual behaviors among Latin American populations is both limited and, as with most countries, very incomplete. Preliminary analysis suggests higher rates among men—consistent with other countries—and more frequent occurrence of fetishism, voyeurism, and incest relative to other behaviors. The relative interplay between legally restricted activities (e.g., voyeurism and incest) and psychological issues (e.g., fetishism) is neither delineated well nor understood.

With respect to sexual identity related to transgenderism, health care systems are generally ill-equipped to assist these individuals, who tend to experience discrimination not only by the health systems but also by society at large. At the same time, most Latin American countries have a tradition of tolerating some variations in gender identification and since 2014 many countries have recognized the need for developing and implementing comprehensive (sexual) healthcare programs for both transgender and LGBQ populations. Such programs are well under way in some countries such as Brazil.

11.6 Implications for Practice

A health professional working with Latin American populations, whether in Latin America or elsewhere, should be aware of the common trends of the region, highlighted in a recent panorama: an abrupt decline in fertility in most countries, little change nuptiality and levels of celibacy, and important progress in educational achievement, coupled with worsening conditions of social inequality and poverty. High levels of violence against women, homophobia, and unsafe abortion are also part of this *machismo* and religious cultural context, which surprisingly does not prevent diversity of sexual patterns or lower the risk of sexual diseases.

What may be deduced from this situation, therefore, is that rising education levels have not affected all social strata equally, and that deep-rooted convictions still

dominate the attitudes and behavior of a portion of the population because many individuals have no access to new/accurate information or they refuse to abandon old beliefs. Providing greater education to all socioeconomic groups and, in particular, more sex education to younger generations in Latin America requires better preparedness of primary school teachers through training by health professionals. Health professionals, in turn, should be educated more about sexual health and response through their professional training programs.

Achieving such measures depends on an alignment of public value and power. To the extent that large-scale change in public policy does not occur, it is yet incumbent upon health professionals in Latin America to work on a paradigm shift with their patients by providing accurate information regarding sexual health and disease that can help overcome long-standing cultural biases related to gender roles and expectations and that can address issues of sexual and gender diversity within the population. Routine consultation with medical and health professionals can assume a major role in this process. A proactive attitude is fundamentally important so as to overcome patients' discomfort and/or reluctance to initiate conversation, ask questions, and resolve doubts and anxieties in clinic visits. Critical to this process is the health professionals' own level of comfort in discussing sensitive issues surrounding sexuality, as well as their acceptance and resolution of their own sexuality.

Box 11.1 Major Takeaways

- The curricula of most Latin American universities included few or no modules about sexual health in family planning, public health, gynecology, urology, or general medicine courses, indicating the need to better integrate information about sexuality into the Latin American medical school curriculum.
- High levels of violence against women, homophobia, and unsafe abortion are part of *machismo* and religious cultural context in Latin America, which surprisingly does not prevent diversity of sexual patterns or lower the risk of sexual diseases.
- Developing a positive attitude toward gender equality means breaking free from the typical male role as virile, promiscuous, and dominant, and from the female stereotype as innocent, submissive, and self-sacrificing.
- The correlation between ED and psychological states such as depression has been well documented in Latin American countries, although the direction of causality is unspecified, most likely being bidirectional (i.e., ED may follow depression and depression may be a consequence of ED).
- The relationship between education and orgasm ability in Latin American women could be explained by the fact that more educated women may be more knowledgeable about their bodies and sexual function, the result of having greater access to information about sex and general health.

- Further study needs to determine whether unconventional sexual behaviors among Latin American populations present a pathway to the diagnosis of paraphilic disorder or other psychiatric disorders.
- Dissatisfaction with one's gender (gender dysphoria) rather than the pathologization of transgender identities has led to significant initiatives in various Latin American countries to address issues of healthcare access among this population, with significant programs and progress documented.
- The rarity of sex education programs in Latin America has forfeited the opportunity to educate youth and adults about sexual health and gender equality, both of which have the potential to mitigate issues related to sexual victimization, adolescent pregnancy, and sexual satisfaction and dysfunction.

11.7 Conclusion

The research conducted for this chapter on Latin American and Latino/Latino issues in sexual health reveals the lack of in-depth knowledge about these topics, as well as the need for more research on sexual behavior, sexual activity, and sexual difficulties/disorders of this population. In many instances, sexual issues reflect larger trends characteristic of other parts of the world, but for some issues, Latina/Latino cultural attitudes present specific challenges that need to be understood and overcome at the individual, relational, and societal levels. Future research should not only attend to such issues as sexual conduct and the persistence and overcoming of gender imbalance, but should rely on carefully defined constructs and terminology. The negative effects of social inequality—affecting living conditions and the exercise of sexuality—must also be considered, as these are often associated with sexual discrimination that interferes with sexual and reproductive rights.

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Cultural Issues Impacting the Acceptance of Psychosexual Therapy

12

Kathryn Hall

Psychosexual therapy, or sex therapy as it is more commonly known, is the combination of psychotherapy with behavioral interventions focused on alleviating symptoms of sexual distress and/or improving sexual satisfaction. While the psychotherapy dimension may have roots in a variety of theoretical orientations such as cognitive-behavioral, psychodynamic, humanistic-existential, and family systems, it is the focus on patients' sexual complaints as well as the use of behavioral interventions to teach new skills, improve the experience of pleasure, and enhance communication that unites these therapies under the umbrella term of sex therapy. The underlying premise of sex therapy is that sexual problems are biopsychosocial in nature; in other words, sexual problems are both caused and maintained by a combination of biological, psychological, and social/cultural factors. Treatment is therefore targeted at these factors. Even when the cause of the sexual dysfunction is biologically based, sex therapy in addition to pharmacotherapy, surgery, or other medical interventions has been found to improve outcomes [1]. Indeed, a collaborative approach with sexual medicine is the current practice standard for sex therapy in the West.

The relevant issue for this chapter is whether and how to adapt a psychosexual therapy developed in the West for a more culturally diverse patient population. The challenge should be greatest where there is a large gap in values between the culture in which sex therapy was developed and the culture of the target population. This chapter will therefore focus on the acceptance of psychosexual therapy in more traditional cultures, here defined as those cultures with sexually conservative (often religiously based) values which lead in practice to a restriction on sexual activity within marriage; absent or religiously based sex education; prioritizing of duty over individual fulfillment; and the privileging of male sexual pleasure over female pleasure. In traditional cultures, women are not afforded the same rights and

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opportunities as their male counterparts especially as concerns decisions over their sexual and reproductive health and behavior.

This chapter begins with a brief description of the context in which psychosexual therapies developed and then examines the underlying values that may impact the acceptance of such therapy cross culturally. An exploration of the practice of sex therapy, including the techniques involved, will be part of this larger discussion. The chapter concludes with suggestions for adapting the practice of sex therapy for patients from traditional cultures and thus focuses exclusively on heterosexual relationships.

12.1 Western Sex Therapy in Cultural Context

Sex therapy was developed in the West, and grew out of the work of Masters and Johnson [2, 3]. Sex therapy found acceptance in North America in the 1960s and 1970s by establishing itself within scientific and medical conventions essentially distancing sexuality from moral and religiously based strictures. The root cause of the sexual dysfunctions was determined to be anxiety, specifically performance anxiety, and soon sex therapy was being practiced primarily by those who specialized in treating anxiety disorders, namely psychiatrists, psychologists, and other mental health practitioners. At the same time, cognitive behavior therapy (CBT) was widely considered the psychotherapeutic orientation of choice for treating anxiety disorders. Sex therapy developed within the cognitive-behavioral framework of providing empirically based, psychologically oriented behavioral interventions targeted at well-defined symptoms.

Sociocultural factors that were considered important to target for treatment were those that existed in a Western context, namely lack of sex education and sex negative attitudes (which were those that invalidated the importance of sexual pleasure for both men and women). The sociopolitical environment of the 1960s and 1970s in which sex therapy developed was defined by the women's movement for equal rights and newly available access to oral contraceptives. The focus of sex shifted from procreation (or prevention of) to pleasure. Equality meant that women were entitled to sexual pleasure to the same degree as men and the diagnostic protocols of that time reflected this parity with sexual dysfunctions being essentially the same across genders, a situation that existed until the last iterations of the major diagnostic systems (DSM-5 and the ICD-11) [4, 5]. In the 1970s, Helen Singer Kaplan and Harold Leif independently advocated for the addition of desire to the universal human sexual response [6, 7]. Variously described as an interest, a motivational state, or a drive, sexual desire was presumed to be the necessary precursor for sexual behavior [8].

To summarize, sex therapy is a psychotherapeutic modality focused on improving sexual pleasure; it is a therapy that has its roots in medicine, psychology, and empiricism rather than spirituality, religion, or morality. The main criteria defining appropriate or healthy sexual behavior are pleasure and consent, and as regards the latter criterion, agreement is the minimal requirement and desire is the

optimal. On the surface, therefore, it appears that sex therapy would face almost insurmountable obstacles in terms of becoming an acceptable treatment option for people suffering sexual dysfunction in traditional cultures, given their more restrictive and religiously based value system. However, sex therapy has been adapted for various populations including sexual minorities, survivors of sexual trauma, aging adults, and people with varying levels of physical ability [9]. Sex therapy is being practiced in many parts of the non-Western world and the changing demographic of North America means that a culturally diverse patient population is presenting for treatment. It is therefore necessary to examine the adaptations that may make sex therapy acceptable and effective for patients from traditional cultures.

12.2 Translating Traditional Cultural Values into Clinical Practice

Other forms of psychotherapy, most notably CBT, have adapted treatment protocols for patients from traditional cultures with empirical validation of their superior efficacy over non-adapted treatments [10]. Successful cultural adaptations have three main targets: the facilitation of a strong therapeutic alliance, encouragement of patient disclosure, and the development of a shared understanding between patient and provider regarding the identified problem and the treatment goals [11]. Sex therapy presents an additional challenge regarding cultural adaptation as some of the behavioral interventions may test cultural norms.

Box 12.1 Key Issues

- Sex therapy requires modifications to be accepted and effective in traditional cultures.
- The degree of modification will vary depending upon the degree of cultural difference from Western sexual values.
- Modifications should target improvements in the strength of the therapeutic alliance as well as changes in the structure of behavioral interventions.

12.3 Therapeutic Alliance

A strong therapeutic relationship is essential to the success of all forms of psychotherapy, including psychosexual therapy. Cultural adaptations must facilitate the therapeutic relationship such that self-disclosure and compliance with treatment interventions will occur. Importantly, the patient must have confidence that the therapist can help. While the overt characteristics of the treatment provider may differ cross culturally (for example, Chinese patients prefer an authoritative approach over a collaborative style), listening to the patients' stories, empathy, and positive regard

will continue to be the mainstays of the therapeutic relationship and the success of psychotherapy [12]. Demonstrating either a familiarity with the patient's culture and/or a willingness to learn about the culture from the patient has been shown to be important in terms of reducing early termination of psychotherapy [13].

In those cultures in which the "patient" may include not only the person manifesting the sexual problem and their partner, but also the extended family and/or community, the challenge to develop a strong therapeutic alliance is great. Sex therapists have experience working with couples and often conduct group therapy. This experience will help with extending the therapeutic alliance to a wider group, and involves listening to the concerns of involved parties and being careful not to be seen as too closely allied with one person or outcome. Indeed the first therapeutic task may be to listen to all sides and then to develop a treatment plan to which all can agree. In some cases, as illustrated below, the involvement of members of the extended family who have an investment in a successful outcome can be helpful.

A and D were having sexual difficulties of which their parents were aware. D's parents decided they needed to visit, which involved them moving into the couple's one bedroom apartment for 3 months. While this might be a disaster for a Western couple, it helped tremendously in this case. The parents, aware of the problem and of the advice given by the sex therapist for "homework," arranged for the couple to have time and privacy by providing childcare for the couple's daughter, doing routine household tasks, and cooking, which freed the couple to go out on dates and to attend therapy. The parents and the daughter slept in the bedroom, leaving the couple the privacy of the pullout couch in the living room for homework assignments and eventually sex.

The main obstacle in many cultures, however, involves the problem that sex therapists are not accorded the authority to intervene in a couple's sexual relationship. In many countries, the practice of psychotherapy is not well established and professions such as sex therapist, marriage counselor, and sexual medicine physician either do not exist, are too few in number to meet demand, or do not have the trust of the population. Among rural populations, people often turn to spiritual healers for help with sexual problems. Unfortunately many of these healers do not have the requisite knowledge regarding sexuality and sexual dysfunction [14]. If sex therapy is going to make inroads in these situations, it may be helpful to partner with established (religious/spiritual) healers who are given the authority to intervene. Western sex therapy has adopted a collaborative approach with sexual medicine and such collaboration might be extended towards spiritual healers in traditional cultures. Case studies have shown that involving a rabbi in the treatment of Orthodox Jewish couples is often essential to treatment progress [15, 16]. It may also be possible to provide training and education to spiritual healers who could then provide basic sex therapy in a culturally comprehensible frame. The successful integration of mindfulness into the practice of Western sex therapy is evidence that sex therapy can be adapted to incorporate at least some spiritual elements and can provide a template for integrating other spiritual beliefs and practices [17].

12.4 Patient Disclosure

As the psychotherapeutic approaches that are the basis of sex therapy are various forms of talk therapy, cultural prohibitions against talking about one's problems, especially sexual problems and especially to a stranger, will present a barrier to accessing treatment. The admonition to therapists to listen to patients will not be helpful unless patients choose to reveal themselves and the nature of their difficulties. They will be unlikely to do so if they do not understand the need for such disclosure. Language barriers, cultural concepts that do not translate well, and lack of privacy are challenges to the traditional practice of sex therapy.

The lack of privacy is a barrier to honest disclosure and in many cultures a female family member must not only accompany women to appointments but must also stay present throughout evaluation and treatment. Care must be taken not to disaffect the chaperone provided by the family (who may also be an important source of information) lest treatment be terminated. Pairing female patients with female therapists may mitigate the need for such supervision while providing a female chaperone (who is trained regarding confidentiality and who may also serve as a translator) for female patients may be another option. In many cases, therapy will need to proceed with the family's chaperone who should then be considered part of the therapy, even though she will likely report back to the family. Sometimes a chaperone can be an important ally in terms of supporting and encouraging the patient through the difficult process of therapy.

A therapeutic alliance forged with family members who hold authority, as well as apprising all concerned parties of the process and progress of therapy, may mitigate the need for chaperones/informants (as long as the family is assured that female patients are not left alone with male treatment providers). The following case illustrates this need:

G and B had suddenly stopped doing their sex therapy homework assignments meant to help G overcome the vaginismus that prevented intercourse from occurring. Recently B's younger brother had been sleeping on a mat in the same room with the couple. He had been sent to sleep there by B's mother who wanted information regarding progress in consummating the marriage. G refused to do the homework assignments when her brother-in-law was in the same room. Privacy was re-instituted when B's parents were invited to therapy sessions to understand the treatment that was being prescribed and they were periodically updated and informed by the therapist regarding treatment progress. The brother was sent to sleep elsewhere.

Culturally relevant language and terminology should be used to explain the process of therapy and the same is true for the language and metaphors used during the therapeutic process. Translators, if used, need to be aware not only of the language but also of the cultural values surrounding sexuality. Providing accurate information about sex as part of treatment does not necessarily involve correcting patients' terminology; rather whenever possible the patient's language can be used.

H is a newly married woman living in China. She is afraid of having intercourse with her husband despite her wish to do so. She believes that a long time ago her mother somehow locked her vagina so that she would remain a virgin until

marriage. H does not know how to unlock her vagina and fears that she will never be able to have a child.

While educating her regarding genital anatomy and the pelvic floor muscles that are *locking*, the process of arousal may be explained to H as the method that *unlocks* the vagina, dilators might be similarly employed to help with *unlocking*, and Kegel exercises will build awareness and control of the *lock*. She can be reassured that since she is married, it is now the appropriate time to *unlock* her vagina.

In some cases, spiritual advisors can be consulted to help formulate culturally relevant language and explanations. Questionnaires and written forms should be used sparingly if at all. Illiteracy, translation difficulties, and the impersonal nature of written assessments risk alienating patients [18]. Sometimes the therapist is left to guess at the nature of the problem, and listening to the patient's story is essential as the following case demonstrates.

P, an undergraduate student from India attending a prestigious American university, came for counseling with the fear that she was "going crazy." She described trying to relax in her dorm room and watching American daytime soap operas, as watching Hindi soaps had been a favorite pastime for her. However, instead of feeling relaxed, P described disturbing sensations in her genitals which had led her to "touch myself down there." Instead of calming the sensations, her hand on her genitals resulted in feelings that she could only describe as "crazy" and that made her want to touch herself again. P was distracted and disturbed by these feelings, could not concentrate on her studies, and feared that she would fail her classes and be sent home to India in disgrace. While clear to the therapist that P was masturbating to orgasm, the process was described to P as her body being ready for marriage, which she was postponing to complete her education. She was assured that she was not ruining herself, but keeping herself a virgin for her future husband (she anticipated an arranged marriage after she completed her degree). It was discussed that she was learning what her body liked and that she would be able to help her husband understand this when she had the opportunity to be sexual with him following the marriage. The term masturbation was never used. P, much relieved, was able to focus on her studies and enjoy her private sex education moments.

12.5 Shared Meanings

The development of a shared understanding of the nature of the sexual problem will extend authority to sex therapists to intervene and will increase compliance with Western-based treatment interventions, some of which may test cultural norms [18]. Sometimes developing a shared meaning is the treatment, as the case of P demonstrates. At other times, as in the case below, more intervention is needed.

S is highly anxious about his recently arranged marriage, which will take place in less than a month. He has furtively masturbated since adolescence and is convinced that this behavior has weakened him and made him incapable of having sex. He has tried to stop masturbating in order to restore his energy, but he has so far failed to be abstinent for longer than a week. Stomach pains, heart palpitations,

shortness of breath, and weaker erections are current symptoms that validate his fears. He is seeking help to resist masturbation, to restore his strength, and to insure that he will be able to have sexual intercourse on his wedding night.

While performance anxiety and lack of accurate knowledge regarding sex may also explain the above symptoms, the patient has a markedly different understanding of his anxiety; he presents with an urgent need for a rapid resolution and he appears oblivious to the importance of attraction to his future wife. S is unlikely to understand how talking about his problem will help, he will be resistant to seeing his fear as based on irrational beliefs, he will not be amenable to any intervention that might involve stimulating himself as proof of erectile ability as he believes that masturbation is the source of his problems, and he needs help quickly. S might be diagnosed with Dhat syndrome, which encompasses a variety of symptoms including physical weakness and sexual dysfunction due to loss of semen [19]. He may also be suffering from handkerchief stress, a term coined to describe the severe anxiety men feel related to the pressure to perform sexually on the wedding night, with little if any sexual knowledge and experience, and with a similarly naïve and often unfamiliar partner. The handkerchief of the name refers to the need to produce a blood stained cloth as proof of the groom's virility and the bride's virginity [18].

S's treatment demonstrates how the practice of Western sex therapy may be situated within the patient's cultural understanding. Treatment involved a medical examination (blood test and semen analysis) that was unremarkable. This assured S that he had not "ruined" himself. Nevertheless, he was prescribed a multivitamin to help him with his overall health. He was advised to stop masturbating only for 3 days at a time and to stop masturbating 3 days before his wedding night. Since this was something S could already do, making this time frame the goal gave him a sense of control that he otherwise did not have. When he did masturbate, S was given the instruction to masturbate to erection, to let the erection subside, and then to masturbate to erection again. This exercise allowed S to experience the reliability of his erectile capacity. Sex education with specific information regarding how to pleasure his wife and have intercourse reduced his handkerchief stress (performance anxiety) and he was indeed able to consummate his marriage on his wedding night.

12.6 Adaptations to the Techniques of Sex Therapy

12.6.1 Psychoeducation

Psychoeducation is a cornerstone of sex therapy, often being one of the first lines of intervention. Sociocultural definitions of virginity and the importance of this status often extend to sexual knowledge, and strict adherence to this definition may leave many young people sexually naive. Many cultures leave the teaching of sexuality to religious institutions which educate young men and women, usually just prior to their wedding, on the religiously appropriate manner in which to have sex. Religious institutions and religious adherents will not likely want to cede control over the timing and content of sexual knowledge, and the concern will be raised that what is learnt in sex

therapy will be at odds with what is religiously acceptable. It is important to be knowledgeable regarding cultural values and work within that value system rather than directly challenging it or treating cultural values as "irrational beliefs." Here again the need for collaboration with spiritual/religious leaders is apparent [16, 18].

It is not unusual that psychoeducation incorporates pictures, drawings, or video depictions of genital anatomy, sexual positions, and sex therapy techniques, all of which may be shocking to patients in traditional cultures. It is best to start with line drawings if illustrations are needed. In P's case, the therapist drew a sketch outlining the external genitalia as P expressed fear of looking at the pictures and diagrams the therapist had on hand.

12.6.2 Cognitive Restructuring

Anxiety inducing beliefs regarding the meaning of sexual behavior and the imperative for sexual performance may not be adequately addressed simply by providing accurate sex education. Challenging irrational beliefs and ideas, as opposed to trying to change culturally held values, will often be necessary and helpful adjuncts to therapy [20]. In the case of S, cognitive restructuring was used to target the irrational belief that if he lost his erection during sex, he would have "failed." Combined with the experiential exercise, S had an alternate view of losing his erection; rather than a failure it was a temporary condition that he knew how to rectify.

12.6.3 Self and Other Pleasuring

Sex therapy combines talk therapy with experiential exercises. The value of these activities is to learn new skills, replace negative associations of sexual touch with positive and pleasurable ones, and to practice communication about sexual preferences with partners. Sensate focus is a staple of sex therapy dating back to the early days of Masters and Johnson [3]. It involves a series of exercises designed to help couples experience the pleasures of touch without the demand to produce a specific response (such as erection or arousal) for themselves or their partner. Sensate focus is one of several sex therapy techniques that involve expanding a couple's sexual repertoire away from the high demand, high pressure, and high anxiety of intercourse. The therapist must be aware of cultural proscriptions regarding certain types of touch as even suggesting some activities may offend or alienate patients. When in doubt, asking first is always a better choice than determining the reaction after the suggestion is made. Likewise, where the culture discourages verbal communication, non-verbal communication between partners can be substituted. And if communication about pleasure is not acceptable, then communication can be proposed as a form of encouragement to one's partner or feedback to help the partner learn or understand the way to have sexual intercourse.

Touch exercises such as sensate focus are meant to be pleasurable and may result in sexual arousal and orgasm. A gradual approach may help patients feel more

comfortable with the sensations associated with increased sexual pleasure leading to orgasm. However, given that extra-vaginal ejaculation is prohibited in some cultures, many men may find it difficult to navigate high levels of arousal without the anxiety that they may ejaculate [15]. The therapist must be aware that there is a cultural value placed on semen preservation in order to help couples navigate through pleasuring exercises. Sometimes a religious leader can grant an exception for medical necessity so that a male patient may be permitted extra-vaginal ejaculation. In cases involving female genital pain with penetration, ejaculation at the opening of the vagina (without penetration) may satisfy religious requirements. This is especially important for sex therapy exercises that may involve self-stimulation. Masturbation is an important step in the stop-start method for the treatment of premature ejaculation, for example. The stop-start method may need to be modified such that ejaculation does not occur, or more helpfully a religious authority may be consulted to grant an exception for medical need. It is the author's experience when working with Orthodox Jewish couples that this exception is given as long as the Rabbi is informed of the treatment strategy. Periodic blood tests and physical checkups may reassure an anxious patient that he has not been weakened by more frequent ejaculation.

12.6.4 Vaginal Dilation

The use of vaginal dilators, or asking the patient to insert her own fingers into her vagina are common techniques to help women with sexual dysfunctions related to pain or fear of penetration. These techniques may interfere with the need for a husband to prove his virility by being the one to penetrate his wife's "intact" vagina. In some cases, using his fingers, or having the husband use the dilators is sufficient, but in other cases men may assume that non-consummation of the marriage is their failure to be sufficiently potent. While Westerners may appreciate a man reluctant to force penetration in light of his partner's fear or resistance, men from traditional cultures might assume that they should be able to perform despite these reactions, which are expected and anticipated, at least during the initial sexual encounter [21]. In situations in which the husband's penis must be the first and only thing to penetrate the vagina, education and instruction regarding arousal and sensitivity to the timing of penetration can help. Explaining that the vaginal opening is not fully covered by an "intact" hymen that needs to be "broken" may indeed help alleviate anxiety and fear for both partners.

12.6.5 Setting Realistic Treatment Goals: Knowing When Not to Intervene

In many traditional cultures, women's sexual desire and pleasure is, at best, seen as irrelevant, but more often it is viewed as dangerous. Newspaper reports of "honor" killings, stoning, forced marriages, and abductions may shock Western sensibilities,

but are often condoned as necessary to ensure the integrity of a family, a community, or even an entire culture. Female genital cutting often significantly interferes with the experience of sexual pleasure [21]. In traditional cultures, women fear bringing shame upon themselves and their families, and/or hurting their chances for marriage if they are known to have prior sexual experience. In traditional cultures, a woman's body is not her own, and she cannot follow her own desires and inclinations when it comes to choosing a partner or deciding when and how to have sex. In situations where a woman or girl is forced to marry a man she may not have any attraction to or love for, or where she is married as a child before she has developed sexually, sexual dysfunctions such as lack of orgasm, arousal, or desire and the presence of pain should not be diagnosed but rather seen as understandable reactions to grim situations [22]. It is absurd to expect any woman to enjoy sex when she has no culturally sanctioned right to choose her own partner(s), to refuse sex or to regulate her own fertility, and when she may be simultaneously denied the right to education, employment, and personal liberty. Domestic violence is a serious concern confronting women worldwide [23]. In these cases of marked inequality and/or violence, sex therapy has no place.

12.6.6 Setting Realistic Goals: Improving Sexual Pleasure

Even in markedly less dire circumstances, cultural and societal pressures act more strongly to inhibit and constrain the sexual behavior and experience of women [24]. Although some religious traditions, such as Orthodox Judaism, place a high value on sexual pleasure within the context of marriage, the transition from preserving virginity to sexual pleasure is often quite difficult. Even when women have an expectation of sexual pleasure, they may lack the skills necessary to make this happen and their male partners either may not share this expectation or may similarly be ignorant of how to pleasure their partners. In such situations, it may be easier to revert to "dutiful" sex [25].

W, an Orthodox Jewish woman accepted an arranged marriage with M after meeting him on three occasions. She was not sexually attracted to M, but on reflection realized she did not even know what sexual attraction was nor did she understand its importance for pleasurable sex. After over 10 years of dutifully having sex she neither wanted nor enjoyed, and following the birth of their fourth child, it was M, not W, who complained about the lack of enjoyable sex. M felt that his enjoyment was being curtailed by W's lack of enthusiasm for sex. So W, as the identified patient, came to sex therapy by herself.

Sexually conservative values, including the belief that women should be sexually passive, are linked to higher levels of sexual dissatisfaction in both women and men [21, 26]. As the above vignette illustrates, sexual pleasure for women is often valued but only when situated in the context of male pleasure. While this may not be an acceptable situation in the West, it at least provides some pathway to pleasure for women in other parts of the world.

In treatment, W learned to identify sources of her own sexual pleasure and she developed the communication skills to teach M how to touch and stimulate her to

arousal and orgasm. W loved M, but was still not sexually attracted to him. Even so, she began to look forward to sex with him as a pleasurable activity. M was never directly challenged regarding his belief that W suffered from a sexual dysfunction. In fact, he was never seen in therapy but his behavior changed as he discovered that his own pleasure was enhanced by his wife's pleasure. He called at the end of W's therapy to express his appreciation for the changes he experienced with his wife.

Often family members arrange marriages for their offspring with a focus on compatibility of values, religion, and status rather than Western-based values of love and sexual attraction. Sex is expected to occur in many countries and cultures irrespective of sexual attraction and desire (especially for women). Sex research that has reexamined the importance of sexual desire (lust) as a driver for sexual behavior has resulted in models of sexual behavior that are motivated by a variety of other factors that have more relevance for arranged marriages. Basson has identified emotional reasons for having sex as well as situations in which arousal may precede and drive desire; the Incentive Motivation model describes situations in which sexuality can be prompted by the expectation of pleasure and Barlow's model emphasizes different feedback loops that contribute to functional (pleasurable) or dysfunctional sexual outcomes [27–29]. In this way, sex therapy will require little adaptation to understand and intervene in relationships in which sex is motivated by a deeply felt sense of duty, companionate love, a wish to conceive, or a concern for the preservation of marital harmony, as long as pleasure is a possibility.

Box 12.2: Takeaways

An open approach is necessary for culturally adapting sex therapy.

- Be willing to learn about the patient's culture.
- Collaborate with culturally sanctioned authorities such as religious leaders and spiritual healers.
- Extend the definition of the identified patient beyond the individual or couple to include important family members who have a vested interest in the successful resolution of the problem.
- Do not practice sex therapy in cases where there is domestic violence and/or marked gender inequality which precludes the woman's right to consent or refuse sex.

12.7 Future Directions

It is often left to the skills and creativity of individual therapists to modify their practices for culturally diverse patients. While this chapter has outlined some challenges and potential adaptations, empirical validation as well as some overall guidance in the process of modifying sex therapy for diverse cultures is needed. In essence, one needs to be aware of the key cultural differences that may require adaptation, be willing to collaborate or consult with others regarding these key factors,

and recognize that modifications while necessary may impact the effectiveness of sex therapy interventions. Ensuring that both partners have, at a minimum, the ability to consent or refuse sex is perhaps the single most important prerequisite for the practice of sex therapy. One can look forward to the time when female sexual pleasure is a right accorded to women and not something to be feared, controlled, or repressed. Increasing the possibility of female pleasure will likely enhance male pleasure as well, and alleviate the pressure many men feel to be at least sexually adept. Sex therapy has great promise as a collaborative technique for the improvement of sexual functioning for a diverse patient population.

Box 12.3: Additional Resources

- *Cultural Formulation Interview* provides a framework in which to organize cultural information relevant to diagnostic assessment and treatment planning. It may be found in the Appendix of the DSM-5 (American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Author; Arlington, VA: 2013.) or it may be retrieved from: http://www.psych.org/practice/dsm/dsm5/online-assessment-measures).
- *World Health Organization* regularly publishes information and statistics relevant to global sexual health issues. These can be accessed on their website: https://www.who.int/reproductivehealth/topics/sexual_health/en/
- Francoeur, R. T., & Noon, R. J. (Eds.). (2004). *The Continuum complete international encyclopedia of sexuality*: Updated, with more countries. New York: Continuum International Publishing Group. This is a comprehensive reference book containing information about the sexual behaviors, customs, and values of countries around the world. The content may be accessed for free and searched by country on the Kinsey Institute website: https://kinseyinstitute.org/collections/archival/ccies.php

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Normal or Normative? Italian Medical Experts' Discourses on Sexual Ageing in the Viagra Era

13

Raffaella Ferrero Camoletto

13.1 Introduction

Since the beginning of the twenty-first century, insistent social campaigns—partly due to the banning of direct-to-consumer advertising of prescription drugs in Europe—have been "problematizing" dimensions of male sexual lifestyles and life courses and endorsing their adjustment through medical treatments and pharmaceutical devices. These social campaigns, promoted by professional associations of physicians (urologists, andrologists, sexologists, etc.) and supported, in most cases, by both institutional bodies (including the Ministry of Health) and pharmaceutical companies, are aimed at informing the general population about diverse male sexual dysfunctions and at promoting the medical treatments available. In so doing, they contribute to the notion that male sexual health is a new public issue, and thereby construct a masculinity that needs to be "fixed" and new forms of medical expertise legitimized to treat it (for a previous analysis of these campaigns, see [1]).

This chapter explores how Italian general practitioners (GPs) position themselves within this proliferation of expert discourses on sexual medicine: more specifically, it investigates how GPs, while accounting for their male patients' sexual health problems, tackle the process of sexual ageing. We show how medical discourses embody, convey, and sometimes question the socially available representations and cultural norms defining what sexual ageing is or should be. A key component of this cultural scenario in which medical experts are embedded is the advent of sexuopharmaceuticals like Viagra and its competitors, hand-in-hand with another contemporary feature, the expanding rhetoric of "positive ageing," in its

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various permutations ("active ageing," "successful ageing," "healthy ageing," etc.). At the crossroads of these two cultural phenomena, we witness a transformation in the way people, especially men, perceive and experience age-related sexual changes, with a relevant shift from a notion of old age as characterized by a process of de-sexualization and of "sexual retirement" to a new representation of ageing people as "sexy oldies" [2] or "sexy seniors" [3].

This cultural revolution of a re-sexualization of later life challenges well-established medical—as well as commonsense—understandings of sexual ageing, compelling medical experts to face an open battleground of different perceptions and definitions of what is normal in sexual ageing. Previous research [2, 4–6] has pointed out the difficulties GPs face when dealing with sexual issues, especially with midlife and older patients.

Relying on data from a recent mixed-method qualitative research project carried out in Italy, we analyze how GPs both adopt and question socially available scripts of ageing, gender, and sexuality. In their clinical practice, GPs tend to overlap the natural, the normal, and the normative [7] by medically reframing as "sexual health" what they perceive as an age-appropriate "respectable sexuality" [8, 9] for ageing men and women.

13.2 Beyond Sexual Retirement: The Impact of Positive Ageing and the Viagra Revolution

Gerontologists have criticized the notion of "successful" and "active" ageing because of their neoliberal focus on productivity and their consumeristic anti-ageing approach, both of which restrict the understanding of the ageing process [10–14]. Successful ageing seems to have become one of the contemporary obsessions [15], focusing on individual agency and choice to maintain "busy bodies" [16] and to withstand the cultural markers of old age [12, 17, 18]. As Twigg and Martin [19] pointed out, this opens up "new territory for empirical investigation in which the body is understood as a key site for the operation of new forms of governmentality. The bodies of older people are disciplined and made subject to regimes of fitness and health in which responsibility for ageing well becomes a moral imperative."

Box 13.1
Three narratives on sexual ageing:
- Sexual retirement: the inevitable sexual decline
- Sexuality as progressive: the older, the better
- The sexy oldie: sex for life and the forever functional

Within this framework, a "lifelong sexual function" [20] becomes a primary component of healthy and successful ageing, imposing the new imperative of "sex for life" [21], envisaging a "virility surveillance" [3] by which "the floppy penis"

[22] in ageing men is seen as a warning signal of a precariously abnormal condition, current or future, requiring medically assisted restoration [23, 24]. The so-called Viagra studies have emerged as one of the research streams investigating men's ageing and sexuality within a medicalized frame [6, 9, 25–44]. Thus, the advent of Viagra has triggered a radical transformation in the perception of age-related changes in male sexuality.

In their reconstruction of the previous Western cultural scenario, Potts et al. [36] pointed out how in the pre-Viagra era the prevailing narrative about male ageing was the notion of an inevitable sexual decline, associated with a physiological reduction of erectile ability. Other narratives were available, but less used and less acknowledged, for example, the so-called progressive narrative, interpreting the effects of decreased erectile ability as an opportunity to live a sexuality less centered on penetrative potency, but open to the experimentation of different sources and forms of sex. In the Viagra era, both these narratives have been replaced by that of the "sexy oldie," connecting healthy ageing with lifelong sexual activity following a "forever functional" imperative [20]. Progress then has been re-interpreted in terms of a restoration of youthful sexual skills and of the enhancement of never-attained sexual performances, constructing a new pharmacologically assisted virility [3, 31] and a "cyborg masculinity" [45].

Research on ageing men has outlined, however, the persistence of the narrative of decline. For instance, a study of Mexican men ([9], see also Chap. 2) showed how ED medicines can endanger men's notion of a respectable sexuality and of a mature and responsible masculinity. Sexual difficulties can therefore be redefined as natural sexual changes, rejecting the pathologizing label of sexual dysfunction and the risk of "getting viagraed" by an artificially produced pharma-mediated sexuality [42]. The research literature has also noted that some ageing men may adopt the narrative of progress [[9], 36] as an alternative understanding of sexual ageing: for instance, in her analysis of older Swedish people's accounts, Sandberg [37, 38] introduced the notion of an "intimacy narrative" to frame how her interviewees tended to interpret life-course-related sexual changes as an opportunity to experience different, richer forms of sexual expression.

13.3 Medical Experts Facing Sexual Issues: A Review

While providing a multifaceted picture of patients and consumers, Viagra studies often assign to medical experts the role of transmission chains of a top-down process of medicalization of sexuality. In fact, few studies have investigated how physicians—as either sexual medicine professionals or general practitioners—culturally define and treat life-course-related sexual changes. In what is depicted as medical experts' compliance with the new engine of "pharmaceuticalization," the possibility of their reflexivity and resistance seems to have been overlooked.[1]

[1] For an investigation and introduction to a social debate on this issue in the Italian context, see [1, 44, 45].

A review of the literature provides a picture of scattered, mainly quantitative, research on this topic. In Europe,[2] the most investigated national case is in the UK [2, 49–52], while other national contexts are only partly covered: France [53], Ireland [54], Portugal [55–57], and Switzerland [58, 59]. These studies outline different barriers to raising the topic of sex among both GPs and their (older and not-so-old) patients.

Physicians, on the one hand, describe their own difficulties in addressing sexual issues. The most common justification is the lack of time in everyday clinical practice (e.g., [57]); however, this perception of a time-constraint can be influenced by the cultural belief that sexual health is not a priority issue when dealing with older patients, therefore endorsing commonsensical notions of an asexual old age [51, 55]. Another relevant, recurring barrier is GPs' admission of, and complaints about, a lack of training and education in their academic curricula on such a sensitive topic. For instance, in British qualitative studies, physicians describe their fear and discomfort in initiating a dialogue on sexual issues by adopting catchphrases like "opening a can of worms" [50] or "opening a floodgate" [52].

Box 13.2
GPs' approaches to sexual issues:
- Evasion
- Medical re-appropriation
- Holistic understanding
- Sexological specialization

Because of this combination of lack of time and lack of training, GPs often consider sexual health as an inappropriate and non-legitimate topic to be proactively introduced into their professional interaction with older patients. As a consequence, many physicians adopt a reactive style, limiting themselves to responding to sexual concerns and problems brought to them by patients. However, some GPs acknowledge the importance of their role as gatekeepers of the definitions of healthy ageing and therefore in their "permission granting role" of legitimizing normal and appropriate age-related sexualities [2].

Giami [53], in his qualitative study on French GPs, provides a useful typological summary of approaches to sexual issues. The first approach is "evasion" (*évitement*), involving selective exclusion of, and resistance to, tackling sexual issues due to the abovementioned excuses such as lack of time and pressure from other clinical priorities; irrelevance of the topic for older patients; and fear of violation of patients' privacy and intimacy. The second approach is called "medical re-appropriation," when the GP adopts a relative, partial avoidance by reframing sexual problems as a

[2] On Malaysia for an interesting study adopting focus groups to explore GPs' attitudes towards sexual health outside Europe, see [46].

matter of physiology, infections, contraception, etc., and therefore acknowledging them as legitimate medical problems. The third approach is called "holistic" because it makes reference to GPs' adoption of a more comprehensive understanding of health issues, including sexual issues as a key dimension of well-being. The fourth approach is the quest for some sort of sexological specialization pointing out the importance of specialized training in sexual medicine for GPs' academic curricula and clinical practice.

In this fragmented review of the literature, Italy appears to be lagging behind: among the studies addressing Italian general practitioners' attitudes and behavior within their medical profession, the style of management of sexual health issues seems to be a neglected theme (for an exception among clinical studies, see [60]). This shortfall in research points to the need for exploring the complexity of GPs' accounts of their experience in dealing with their older patients' sexualities.

13.4 Current Study: Context and Methodology

In this chapter, we draw upon empirical material collected within a current multi-method qualitative follow-up research project (started in 2016) on the transformation of representations and experiences of ageing and sexuality in Italy. Previous research (see [1, 46, 47]) carried out in Italy from 2010 to 2015 focused on social awareness campaigns about male sexual health. These campaigns aimed to inform the general population about the diversity of men's sexual problems and to promote obtaining medical advice, thereby constructing a definition of the problem to be solved, the patients to be cured, and the strategies for resolution, including treatments to be adopted. This research project included a thematic analysis of visual and textual documentary material produced by major national awareness campaigns on male sexual health websites and videos ("Amare senza pensieri," 2008–2009; "Amico andrologo," since 2009; "Basta scuse," 2010; "Chiedi aiuto," 2012; "Uomo e salute," 2013); websites on male sexual health managed by medical experts (www.pianetauomo.eu, promoted by SIU, the Italian Urological Society; www.prevenzioneandrologica.it, promoted by SIA, the Italian Andrological Society); and by pharmaceutical companies (www.lillyuroandrologia.it, promoted by Lilly). Nineteen interviews were carried out, along with one roundtable of experts in the field of sexual medicine (urologists, endocrinologists, sexologists, sex counsellors), recruited because of their involvement in these campaigns.[3] In addition, interviews with two groups of product-development and marketing managers from two major pharmaceutical companies' Italian subsidiaries (Lilly and Menarini) were conducted.

The project narrowed the field of investigation by focusing on the impact of the Viagra revolution and of the rhetoric of active ageing on the representations and experiences of sexual ageing and on the controversial notion of ageless sex.

[3] The key limitation of the study depends on the small scale of the sample, restricting the possibility of taking into account the influence of some structural dimensions, mainly gender and age cohorts of the medical experts interviewed.

The project involved an analysis of media and medical documents on older people's sexual health, interviews with GPs (in progress, no. 23), and focus groups and interviews with older people (in progress, respectively, no. 4 and no. 7) in order to explore their perceptions and experiences of sexual ageing.

Here, we focus primarily on the in-depth interviews with general practitioners. The interviews, lasting from 30 to 90 min, have been fully transcribed and submitted to open, axial coding procedures with Atlas.ti software. Following a thematic analysis [61], we have reconstructed how doctors debate the issue of sexual ageing. To summarize how GPs differ in their views of older people's sexual health, we combined the two typologies of the abovementioned qualitative studies ([51] for the UK, [53] for France), identifying five styles of sexual health management: (a) *reactive evasion*, when sexual issues are not seen as a priority or are considered a risky topic to be dealt with only when patients introduce it; (b) *reactive sexological specialization (*or *delegation)*, when sexual issues are delegated to sexual medicine experts; (c) *proactive medical appropriation*, when sexual problems are reframed as medical problems relating to physiology, infections, contraception, etc.; (d) *proactive holistic approach*, when sexual issues are framed within a more general view of well-being; and (e) *proactive sexological specialization*, when GP's training in sexual issues is demanded. In the following section, some of the preliminary results are presented and discussed.

13.5 "Letting Sleeping Dogs Lie": Between Avoidance and Delegation

In Italy, similar to what has been outlined in the abovementioned research in other national contexts, GPs do not appear at ease in dealing with sexual issues in their everyday interactions with older people: sexuality is perceived as a buck to be passed on as often as possible, and to be managed cautiously when unavoidable. Talking about sex, therefore, seems to be legitimate only if patients introduce the topic. GPs fear being accused of invading patients' private spheres, and of their patients' unpredictable reactions when such a sensitive topic is mentioned.

It means being available to help them in relation to this issue … if they mention it … If they don't say anything, it's a bit more difficult for me to initiate the conversation about it because I don't know how the patient will react (GP, female, 60).

These are niche topics, speaking about male patients, since women absolutely don't talk about them because for women to stop having sex after the menopause is perfectly normal. For a man the problem is still present at an older age, but in my experience it is an issue I rarely deal with because I let sleeping dogs lie (GP, male, 52).

Not only are sexual issues perceived as a sensitive, private matter, but some physicians refer to sexuality as an inappropriate topic beyond medical jurisdiction: talking about sex appears to be a more mundane practice to be dealt with in a confessional by a spiritual guide, or within psychological counselling requiring a different kind of professional training and environment. *Some patients reacted with "Mind your own business!" as if they didn't consider this query of professional interest, as if this*

issue were detached from general health … as if it should not be investigated by someone wearing scrubs, but rather by someone wearing a cassock or a psychiatrist (GP, male, 51).

Some GPs, on the contrary, acknowledge the relevance of sexual health and the importance of managing sexual problems, but they tend to delegate this task to specialists in sexual medicine. *If a patient introduces the problem, I take it into account, I give the appropriate therapeutic indications … I always do a checkup, then I send him/her to a specialist … [Sexual issues] are very often related to other pathologies … they are delegated to urologists or gynecologists (GP, female, 51).*

The risk in this approach seems to be that of reducing the GP's role to sorting patients or, as is often admitted, to solving sexual problems mainly or only by prescribing pharmaceuticals.

It is a niche issue, not so often dealt with in general practice. I personally don't encourage the patients very much, that's true, but it's very rare for a patient to talk to me about sexual problems, or if he does it's because he knows there is a little pill, a little help requiring medical prescription, so in the end [my role] comes down to prescribing these drugs (GP, male, 52).

13.6 Proactive Approaches: Sexual Issues as a Door-Opener to the Patient's Healthy Life

In this next section, we see how, for some GPs, managing their older patients' sexual impairment is not only perceived as legitimate clinical practice, but also as an opportunity to build stronger therapeutic compliance. Thus, some GPs claim a more proactive role. This can mean a medical re-appropriation of the investigation of sexual issues, as in this long quotation from a GP for whom managing patients' sexual difficulties emerges as the most satisfying part of his job for two reasons: because it makes the patients happy and meets their real needs, and because it triggers a stronger doctor/patient relationship, empowering therapeutic alliance and reinforcing GPs' professional status. *The best part of my work is the rare occasions when you have direct contact. When the patient comes, takes a seat, opens up, says: "Listen, doctor, I have a problem, things are not going well with my wife." He approaches it indirectly. So you ask: "What do you mean?" "Well, it isn't working properly." So you start to put your heads together, you explain which drugs are available, how they work, how to use them, you crack some jokes … It's different from prescribing antibiotics against bronchitis; maybe it works but the following week the patient doesn't come to say "Thanks." The patient with erectile deficit, if the treatment is successful, comes back with a smile from ear to ear (GP, male, 45).*

The specificity of sexual issues within this approach is re-interpreted positively: no longer perceived as an inconvenient, delicate topic, it acquires the role of door-opener to gain the patient's trust. Moreover, for a few GPs a proactive style of medical management also conveys a more comprehensive and holistic notion of health, including sexual issues as a core dimension: talking about sex is part of an "all-embracing" view of the patient's well-being. *Well, if we want to take into account*

the individual's well-being, we must necessarily manage it [sexual health] too … Well-being is a completion of physical, psychological and—why not?—sexual dimensions. Therefore it is all-embracing, it is present in all our medical investigations (GP, female, 56).

Within this perspective, GPs tend to consider sexual problems as an important sentinel and as predictors of a wider range of dysfunctions and pathologies, and therefore requiring careful, committed medical attention. The acknowledgment of sexual health as a legitimate topic for GPs leads some to admit their lack of an appropriate academic background and to ask for specific training in sexual medicine as a useful tool to deal better with their patients and solve their problems. *In my opinion, it [talking about sex] should be part of our … like when we ask "Does it hurt when you urinate? What does it smell like?" … We should remember to ask it … But first of all, we need scientific evidence … because I wasn't specifically trained for that. So, if we had had specific training, we could intervene more appropriately on certain problems, replacing the smile on our patients' faces. (GP, male, 45).*

13.7 Debating the Sexy Oldie's Health

In addition to the distinction between reactive and proactive approaches, GPs' narratives reveal some ambivalence about the definition of sexual ageing and what is natural or normal in later-life sexuality. As pointed out in Sect. 13.1, medical discourses are enmeshed with cultural beliefs, values, and representations of gender, ageing, and sexualities. The diverse styles of medical management of old people's sexual health problems also channel and express different ways of defining and understanding what is appropriate in sexual ageing. Some GPs seem to introduce a normative dimension into their clinical approach, conveying the new "must" of lifelong active sexuality [20]: older people are expected to continue an active sexual life as part of a healthy lifestyle. Therefore, GPs "willingly" handle the request in order to support their patients' sexual "rebirth" and a lifestyle of "being fully aware of your body." *It is clear that at 70 you cannot perform as you could at 30, but you can (and should) have an active physical—including sexual—life, naturally using different ways and means … People at 65–70 have no sexual life, and I, in my 50s, think this is sad and tragic (GP, female, 51). Let's open GPs' minds to sexuality, please! Because sometimes they are more bigoted than their patients … The aim is to make patients more alive, respecting and promoting sexual activity as producing beneficial effects … What could be better than living healthily, with this lifestyle, being fully aware of your body (GP, female, 56).*

In opposition to this enthusiastic view of later sexuality as a rebirth and reappropriation of an active sexual lifestyle, other GPs outspokenly make reference to an overlapping of natural/biological and social/moral standards in defining age-appropriate sexual conduct [62]. *To increase your performance is a current pipe dream, not only in sex … But I believe, not only as a GP but also personally, that you pay for this. If you go against nature, against the opportunities nature provides, you can end up not being able to use what your age allows. I have some cases in*

mind … Patients who resist my attempts to discourage them from seeking from drugs what nature hasn't given them. And they have lives which are ridiculous in my opinion … What makes me laugh is that they believe they are successful because they perform extraordinarily well. The only evidence is that they have extraordinary brains [laughing], small ones (GP, male, 51).

The quest for a pharmacologically assisted everlasting sexuality is re-interpreted as a consumeristic approach and as an artificial way of coping with the naturalness and inevitability of the ageing process. Moreover, this obsession with sexual rejuvenation exposes patients to the risk of looking ridiculous and paying the price. However, in a few GPs' narratives we find some room for the acknowledgment of a wider range of options of age-related sexual expressions, providing, especially for men, the possibility of moving beyond the sex-machine script. In the following quotation, we see a GP legitimizing different ways of managing sexual ageing: a midlife man who is seeking to ensure his own and his partner's wider well-being, as well as an older man admitting that he is no longer interested in sex after losing his wife. The point is everyone has the right to an appropriate healthy and pleasant sexual life at any stage of the life course, being aware of the different bodily options and pleasure available at different ages.

It reminds me of a patient I had a few years ago, who told me: "You know, I have a new partner and I want to make her feel well, to feel well myself too, therefore … do you think I should do something about it?" I think this is very healthy and positive … Last week a 78-year-old patient told me: "Listen, since my wife [with whom he had lived for 50 years] died last year, I don't desire other women, I don't feel like it," and I replied "I think it's physiological, because you are 80 and you have always lived with your wife," with whom he had an active sexual life. It's absolutely normal … There should be more publicity about the right of a man, even at 70, to have a pleasant sexual life; about the right of a woman, at 15, 60, 70, 103, to have a pleasant sexual life, using different ways and means, which is evidently physiological. At 60 you don't run a marathon, you do a little jogging (GP, female, 55).

The reference to a context-dependent understanding of ageing and sexuality seems to create some room to question a reductionist naturalized notion of sexual functioning in order to recognize the influence of social and cultural dimensions shaping how older people make sense of their sexualities across their life course. However, as discussed in the last section, GPs' accounts more frequently tend to endorse a "healthicization" of sexuality [63] which, in defining what is a healthy sexual lifestyle in later life, merges the natural, the normal, and the normative.

13.8 Conclusion and Implications

In this chapter, we explored the variegated impact of active ageing and ageless pharma-mediated sex discourses in GPs' narratives. In the background, we find some evidence of a process of normalization of ageing through a moralization of (sexual) health [7], a process to be inscribed within a neoliberal notion of good biocitizens responsible for their bodily maintenance [64].

In GPs' narratives, we can detect an overlapping in the definition of what is physiologically, statistically, and socially normal. The boundaries of age-appropriate sexual health seem to be traced back to the gendered script of a "respectable sexuality" [8, 9]: men are expected to walk on the razor's edge of keeping sexually active without becoming "dirty old men" or "sugar-daddies" [65], while women have to find a balance between maintaining sexual desire and attractiveness and avoiding being labelled as cougars or mutton dressed as lamb [66].

GPs can therefore risk affirming or reinforcing a (new?) normative model of a forever-functional sexuality, perceived as a right but also as a duty for older people [34]. As we have seen, Viagra fostered a new ageless virility in which maintaining sexual potency, measured as penetrative capacity, is a signal of good health and of positive/active/successful ageing. However, medical accounts have exposed a tension between the two positions: on the one hand, the acknowledgment of new generations of sexy seniors' right and expectation to maintain a satisfying level of sexual activity, thanks to pharmacological and mechanical devices, and on the other hand, the rejection of a consumeristic approach to sex and the claim to restore the social role of physicians as gatekeepers of sexual health and of respectable sexual ageing. General practitioners' accounts, in their ambivalent definition of the "functional age" at the intersection of biological and biographical trajectories, are emblematic of the "contradictions of 'post-ageist' discourses and practices that promise to liberate bodies from chronological age, while simultaneously re-naturalizing gender in sexed bodies" [62].

Box 13.3: Takeaways

Healthcare professionals need to:

- Acknowledge new generations of sexy seniors' sexual rights
- Challenge consumeristic approaches to sexual health
- Dismantle gender and age stereotypes about older people's sexuality

GPs could also work at dismantling some of the stereotypes and prejudices about older people's sexuality: more specifically, they could endorse what Gott [2] called a "permission-granting role," extending the definitions of normal and appropriate ageing sexualities. In some GPs' accounts, we have found clues as to how to make room for a progressive narrative, acknowledging a wider range of age-related sexual expressions [36, 38], thereby giving legitimacy, for both men and women, to diverse ways of coming to terms with the sexual changes occurring across their life course.

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Part IV

Sexual Differences and Practices in the Context of Cultural Variation: Editor's Notes

This section offers insight into sexual diversity on a variety of topics and from a variety of perspectives. Chapters 14 and 17 offer in-depth analyses of genital alteration—female and male surgery and cutting. Both are controversial topics, with Limoncin and colleagues placing female genital cutting in the context of various cultures, positing that without in-depth understanding of the cultural origins and current meaning of such practices, uninformed criticism and attempts from "outside" forces to quell such practices are likely to meet with limited success. Drenth, taking a different approach, details historical aspects of female and male genital cutting within Western culture, demonstrating how various practices—once considered beneficial (sometimes morally) but now abhorred—have been justified by the biases and concerns of the day, pointing out that even today, controversy regarding male circumcision serves as a reminder that in an era of "evidence-based medicine," cultural biases continue to play a role in how we approach "genital fixes."

The essence of cultural relativism might emerge in the discussion about what a society considers to be "normal" expressions of sex, and what it considers to be "not-normal" expressions of sex. In Chap. 15, Zgourides does an excellent job of discussing paraphilias from a cross-cultural perspective. Given the dearth of cross-cultural studies on the topic, the chapter is grounded in the current (Western) understanding of paraphilias while yet giving nod to the idea that the frequency and way in which such behaviors are manifested, and the societal reaction to those behaviors (in terms of gravity/tolerance) vary greatly over social systems. In Chap. 16, Welsh gives us a rare but critically important look into a world that is often ignored, even denigrated within both society at large and within the field of sexual healthcare specifically—the idea that persons with disabilities have sexual needs and will, in one way or another, find ways to express those needs. Developing sensitivity and competence in interactions with persons with disabilities is imperative: While healthcare professionals can often predict the types of patients (e.g., ethnicities) they are likely to encounter in their practice by dint of their work location, persons with disabilities are found in all societies and all locations.

The final two Chaps. 18 and 19 are somewhat specialized but are intended to raise important questions. Chap. 18 addresses worldwide pornography use and the implications for cultural values when social systems no longer have control over the dissemination of information about sexual practices. The chapter provides data on worldwide online pornography-website use and its soaring increase in developing nations. These trends raise the possibility for social tension/conflict as such sites increasingly become a major source for sex education for youth in countries where little or no competing sex information exists due to the lack of formalized sex education programs (e.g., see Chaps. 3, 9, 10, and 11). Chap. 19 not only recognizes the gap in cross-cultural research related to sexuality and sexual medicine, but also details the rationale and critical importance of such research. The chapter delineates strategies for engaging in cross-cultural sexuality research and shows how such projects might be achieved within the normal operational services of a clinic or as part of any larger multi-national research endeavor.

Pleasure, Orgasm, and Sexual Mutilations in Different Cultural Settings

14

Erika Limoncin, Filippo M. Nimbi, and Emmanuele A. Jannini

14.1 Introduction

Considering all living species, humans are among the most social. In fact, from birth, we develop and live in a social context that inevitably shapes our thoughts, beliefs, and attitudes. It is also largely accepted that social contexts affect attitudes toward sexuality; specifically, the way people live out their sexual lives is tightly linked to family messages and behaviors related to appropriate sexual scripts. One's sexual identity partly depends on gender role, the set of culturally determined expectations that prescribe specific behaviors, traits, and ways of thinking for men and women. For such reasons, attempting to understand sexual behaviors without comprehending the influence of sociocultural factors would seem both misleading and futile.

Such a perspective applies even more cogently to female genital mutilation (FGM), practices that are strictly related to the cultural contexts in which they occur. FGM is defined as "all procedures that involve partial or total removal of the female external genitalia, or other injury to the female genital organs for cultural or any other non-therapeutic reasons" [1]. Generally, the aim of FGM (sometimes broadly referred to as female circumcision) is to *preserve* female sexual "integrity," specifically, to guarantee virginity and potential marriageability following religious and social precepts. Although FGM is often associated with psychological distress, this distress becomes even greater should the woman emigrate to a Westernized society.

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Societies dictate what is considered "normal" or "conventional," as well as what is "abnormal/pathological," or simply "not conventional." In the West, FGM is viewed as a barbaric, patriarchal ritual intended to deprive women of pleasure during sexual intercourse, with the ultimate goal of controlling their sexuality. However, dealing with FGM of local or immigrant women implies the need to know the cultural motives behind this practice as well as women's emotional responses to it.

This chapter provides a brief description of the origins, prevalence, and characteristics of various FGM types, with a specific focus on sexual pleasure and orgasm in mutilated women. Specifically, our intention is to highlight the fact that female sexual pleasure is determined by multiple variables, an outcome that seemingly contradicts the presumed purpose of FGM of depriving the woman of this experience. In the final section, we discuss the necessity of treating mutilated women and suggest how clinicians might deal with this complex issue.

14.2 Origins and Prevalence of FGM

FGM may be described as surgical practices aimed at modifying female genitalia. The procedure usually consists of a ritual ceremony which has important religious meaning and which is accompanied by celebratory music, food, and gifts. FGM is frequently performed by a religious leader, the town elder, or a medical professional with limited or no surgical competencies. The fact that sterilized knives or other cutting implements are often not used in these rituals can, in the worst case scenario, actually cause death. More likely, it may induce significant complications, the most prevalent being extensive bleeding, urination problems, cysts, infections, and complications during childbirth [2]. Due to both purpose and method, FGM is recognized by the World Health Organization (WHO) as a procedure that undermines women's human rights [3]. Classifying the different FGM types is often difficult, because of overlap in procedures. The most widely used classification has been proposed by WHO, which classifies four principal types of FGM (Table 14.1, Fig. 14.1), which may occur individually or in combination.

Historically, the first clearly identified case of an infibulated woman dates back to the 1970s, when the Hosken Report reported the discovery of an infibulated mummy (infibulation involves narrowing of the vaginal orifice with the sealing of the perineum, cutting and repositioning the labia minora and labia majora with or without the excision of the clitoris) [4]. However, the first systematic study on FGM dates back to the 1930s [5]. Currently, female circumcision is practiced in some 30 countries throughout sub-Saharan Africa, the Middle East, and Asia, with an estimated 200 million women (of 3.7 billion worldwide) who have been infibulated [6]. Contrary to popular belief among some, the motives behind the continuation of FGM are exclusively sociocultural (i.e., sexual) in nature and not religious, as evident by the fact that FGM occurs in cultures that have links to both traditional polytheistic and monotheistic religions (Islamic, Christian, Hebraic).

The assumption that very young girls, aged 6–7 or before the first menstruation, should be mutilated is based on a ritual sociological root. For example, families must consent to their daughters' infibulation in order to ensure their marriageability

Table 14.1 Types of female genital mutilations (FGM) categorized by the World Health Association (WHO) [1]

Type I: Clitoridectomy (removal of the clitoris and/or the prepuce) *Type Ia*: removal of the clitoris hood or the prepuce *Type Ib*: removal of both the clitoris and the prepuce
Type II: Excision (partial or total removal of the labia minora without mutilation of the labia majora) *Type IIa*: removal of the labia minora *Type IIb*: removal of the labia minora and partial/total removal of the clitoris *Type IIc*: removal of the labia majora, the labia minora, and the clitoris
Type III: Infibulation (narrowing of the vaginal orifice with the sealing of the perineum by cutting and repositioning the labia minora and labia majora with or without the excision of the clitoris) *Type IIIa*: removal and apposition of the labia minora *Type IIIb*: removal and apposition of the labia majora
Type IV: all harmful procedures carried out without medical purpose to the female genitalia (herbal treatments, cutting, piercing, incision of the vagina (*gishiri cuts*), abrasion of the tissues near the vaginal orifice (*angurya cuts*))

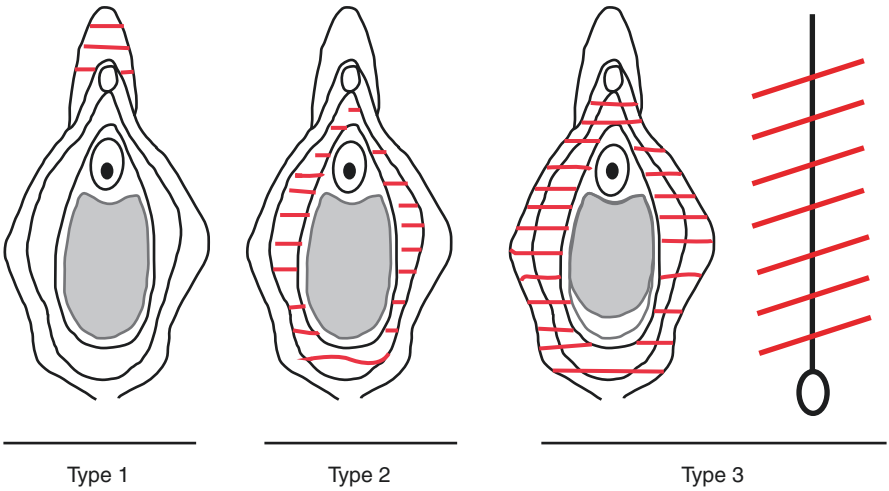

Fig. 14.1 The three types of female genital mutilation (FGM). The red lines represent the regions of female genitalia surgically treated. See Table 14.1 for explanation

in adulthood. It is believed that this procedure maintains girls' chastity, preserves fertility, improves hygiene, and enhances sexual pleasure for men. Hence, FGM may be seen as an initiating rite of passage to womanhood and formal entrance into society. Indirectly, all FGM procedures promise a reduction of female sexual desire and thus any inclination toward her having extramarital sexual intercourse. Because of these characteristics, FGM is viewed as a public health issue that requires deep cultural competency/understanding to be addressed. Successful approaches include reinforcing the positive aspects of local culture rather than demonizing traditional practices, using the media to elevate the status of being uncut, human-rights education linked to local values and aspirations, and the development of linkages with

neighboring countries and countries of migration. Non-traumatic, symbolic rituals might also substitute for actual mutilation as the education level of the population rises.

14.3 Female Pleasure, Orgasm, and Related Anatomical Areas

Empirical evidence showing that some mutilated women are able to experience sexual pleasure and orgasm despite substantial genital damage illustrates the necessity to re-examine the origins of women's sexual pleasure and orgasm. It is reasonable to suppose that some types of FGM do not directly damage clitoral innervation except in the case of clitoridectomy and certain kinds of infibulations as described in Table 14.1. Furthermore, the specific sexual stimulation that triggers orgasm varies greatly across women, as well as within women over various situations and occasions. Orgasm might be reached by either direct or indirect clitoral stimulation, and/or with touching of internal areas surrounding the vagina. The research literature shows that about 30–40% of women do not experience orgasm with only vaginal penetration, leading to the possible conclusion that there are two different anatomical structures (responding to two different kinds of sexual stimulation) involved in the female experience of orgasm [7].

Historically, from a sociocultural point of view, male orgasm has never been a point of controversy; in contrast, female orgasm has often been the subject of debate, ever since the middle of the nineteenth century (e.g., and flamed by Freud's distinction between adult vaginal orgasm and immature clitoral orgasm). The dilemma centered not only on the existence of one vs two (or more) types of female orgasms, but also (more recently) on the evolutionary "utility," from a reproductive perspective, of the female orgasm itself. For example, Symons, Lloyd, and others [8, 9] have questioned whether female orgasm offers any survival advantage or is even a true product of sexual selection, rather than just an evolutionary by-product. Clearly, women who enjoy pleasurable sex are more motivated to have intercourse, and hence more likely to reproduce and propagate this characteristic in future offspring. However, data regarding a specific evolutionary benefit of the female orgasm are lacking.

The discussion regarding different types of female orgasms, and specifically the idea of vaginal orgasm as a "mature" form of pleasure, has been suggested since the turn of the twentieth century [10] and has had broader political and sociocultural roots than had been believed [11]. This debate, now spanning nearly two centuries, can be summarized in three fundamental stages: (1) the controversy related to the theory that women not experiencing vaginal orgasm are affected by hysteria [12]; (2) the feminist protest of the 1960s, asserting that clitoral orgasm has the same value as vaginal orgasm, with the difference that clitoral orgasm is free of male sexual penetrative intercourse [13]; and (3) the more recent search for an anatomical and functional locus of the female orgasm, that is, of the Gräfenberg spot (G-spot), renamed in recent years as the clito-urethro-vaginal complex (CUV) and representing dynamic interaction among the clitoris, urethra, and anterior vaginal wall to produce orgasm [11].

Box 14.1 The History of the Controversies, and the Controversial History of the Female Orgasm

In the seventeenth century, the argument about the existence of one or two female orgasms did not attract much interest among scientists, probably because female sexuality and female pleasure did not represent a culturally interesting topic. On the other hand, FGM demonstrated the exact opposite; in fact, the cultural motivation connected to these procedures highlights the attention to female pleasure and to its control, or, in some cases, to its increase. Hence, one way or another, through FGM, we can suppose that, based on the remains of Egyptian mummies, there has existed an interest in female sexual pleasure since ancient times.

Although at one time it was thought that female orgasm facilitated procreation, the development of new research methods debunked this myth. In fact, researchers discovered that women could successfully reproduce without having an orgasm. Having demystified this assumption, the debate about the "utility" of the female orgasm began. In 1875, when the biologist Edouard Van Beneden described for the first time the biological mechanism of fertilization [14], scientists, thinking about the clitoris and about its role in procreation, concluded that probably neither the clitoris nor the orgasm played a role in reproduction. This discussion slightly preceded the debate about hysteria, a dominant disorder in Western society at the end of the nineteenth century. The first description of this particular disorder, which affected mainly women, originated with the neurologist Jean-Martin Charcot. Interestingly, since the utility of the clitoris had not been discovered, some authors proposed that symptoms of hysteria derived from damage to, or a dysfunction of, the clitoris. This hypothesis brought to the fore the belief that excision of the clitoris could cure hysteria and other forms of female diseases [15]. This procedure, a true Western ideologically driven FGM, was carried out until the beginning of the twentieth century. As for hysteria, it was speculated that, in some way, the clitoris was connected with female psychological well-being.

The twentieth century was also the time when Freud developed the first theory of human sexuality. In regard to female orgasm, Freud's theory had a profound impact on the development of the belief that the only "true and mature" kind of female orgasm was the vaginal one. In contrast, attention given to the clitoris was considered by Freud to be an expression of the frustration resulting from the absence of a penis. Freud affirmed that only through the surrender of clitoral stimulation and an immature kind of orgasm might the woman be considered not frigid, thereby developing a mature sexuality. Based on the Freudian theory of penis envy (German: Penisneid), various writers [16] continued to affirm the immaturity of clitoral orgasm and the importance of vaginal orgasm, as the latter represents the only kind of orgasm involved in penetrative (and hence hypothetically reproductive) intercourse. One of the few authors challenging this idea was Freud's pupil, psychiatrist Wilhelm Reich, who developed an interesting theory about the political and cultural function of the orgasm: for him, female orgasm was as important as

male orgasm. Once again, female pleasure, as well as the role of the clitoris and that of the vagina, seemed to be strictly connected with the culture.

In the 1950s, with the advent of one of the first scientific studies on human sexuality carried out by Alfred Kinsey, the central role of the clitoris in female sexual pleasure was described. In line with these studies, a later report by Shere Hite confirmed the importance of the clitoral orgasm for female pleasure [17]. However, the debate did not stop there. The 1960s also marked the years of Masters' and Johnson's seminal studies. These authors developed, based on the screening of about 10,000 individuals, a new conceptualization of female orgasm, beginning in the clitoris and extending to the vagina. They first proposed the concept of a unique anatomical structure, connecting the clitoral innervations with those of the vagina [18]. These years were also characterized by the advent of feminism. On the one hand, feminism advocated for the recognition of women's civil rights [19] and, on the other hand, stressed the idea that the clitoris was not merely an atrophied penis, and that women did not need penetrative intercourse to enjoy sex, thus halting research on the topic until the 1990s. During that period, the concept of the region later named the CUV complex was rekindled. Although the CUV complex had been known and "used" in sexual intercourse among Eastern societies since ancient times, in Western societies it was essentially ignored until reported by gynecologist Ernst Gräfenberg [20] in the 1950s. Gräfenberg recognized the role of a "specific point" in the vagina near the urethra for inducing the vaginal orgasm, if properly stimulated. In subsequent years, Beverley Whipple, together with colleagues, published a book for the general public that stressed the importance of the G-spot for female pleasure [21], and hence the debate about female pleasure intensified. This discussion was later supported by anatomical and physiological studies aiming to discover the specific area connected to the vaginal orgasm [22, 23]. The most intriguing findings were described by the urologist Helen O'Connell, who, by dissecting cadavers and using MRI scans, demonstrated that the clitoris was larger and more innervated than was apparent in the pictures found in anatomy texts of the twentieth century [24, 25]. Using ultrasound techniques, recent studies evidenced that the cavernous bodies of the clitoris descend to the lower part of the anterior wall of the vagina during a reflex or voluntary contraction of the anus elevator muscles, resulting in a vaginal orgasm [26]. These studies were further supported by more recent investigations of the functional anatomy of the CUV complex. This functional anatomy suggested the existence of (at least) two types of orgasm: in the case of clitoral stimulation, that is, when an external stimulation of the glans and the raphe is performed without voluntary perineal contraction, the cavernous body of the clitoris is almost inert and its root does not seem involved; and in the case of a vaginal stimulation, when the vagina distends itself due to penetration. During this latter type of stimulation, the root of the clitoris comes closer to the lower anterior vaginal wall. Hence, the contact between the vagina and the clitoris is enhanced, resulting in a broader female

orgasm [11, 27–29]. These findings re-established the vagina as a zone of female pleasure, creating a link between the clitoral and the vaginal orgasm.

Knowledge about CUV may also partly explain why some women affected by FGM experience sexual pleasure during intercourse. In some cases, the neural, muscular, and vascular components of the CUV during surgical procedures may be preserved, making it possible for women to reach orgasm. However, there are probably other variables involved, perhaps strictly cultural, that affect orgasm. In the case of FGM, it may be speculated that culture (as much as genital cutting) interferes with the pleasure and orgasm.

14.4 Short- and Long-Term Consequences of FGM

Generally, the use of unsterile cutting objects, together with the absence of antiseptics or antibiotics, increases the risk of developing short- or long-term consequences in FGM women [30]. Among the short-term primary infections, the most frequent are staphylococcus infections, urinary tract infections, excessive and uncontrollable pain, and hemorrhaging [31]. Various types of infibulation may also increase the risk for infection of human immunodeficiency virus (HIV), *Chlamydia trachomatis*, *Clostridium tetani*, and herpes simplex virus [31]. Beyond these short-term consequences, the most common long-term consequence is the development of keloid scar tissue over the cut area [32]. Entrapped nerves within the scar may develop neuromas, leading to severe pain especially during intercourse [33]. Other long-term complications include cysts, hematocolpos (vaginal retention of menstrual blood), dysuria, recurrent urinary infections, and infertility. From the psychological point of view, FGM is associated with post-traumatic stress disorder (PTSD), anxiety, depression, somatization, phobia, low self-esteem, and psychoses [34, 35]. In particular, PTSD is often related to FGM-induced difficulties during childbirth; in such instances, the genitals often have to be cut in the perineum area to allow for the baby's passage [36]. Specifically, the prevalence of PTSD in Senegalese women was shown to be significantly higher for those with FGM than in women without FGM [37].

These psychological complications, together with the need to establish re-identification with the cultural background, have led some women to request reinfibulation after childbirth. Such requests need to be managed with sensitivity, considering different variables, including the country where the woman lives, her beliefs, and the beliefs of the physician about FGM.

14.5 The Impact of FGM on Pleasure, Orgasm, and General Sexual Quality of Life

Pleasure and orgasm are two aspects of sexual response which, especially for women, are determined by several variables, including the menstrual cycle phase, the quality of the intimate relationship, sexual attraction toward the partner, and so on. In the case of women who have undergone FGM, the experience of pleasure and

orgasm is modulated by a number of additional variables, for example, sociocultural influences, and in particular social acceptance, educational level, adherence to cultural values, and length of time the woman has lived in the host country [38].

Because of the impairment of and modification to the genitalia, it is natural to assume that FGM would significantly worsen a woman's sexual life. However, the literature is controversial in this regard [39]. Disparities in results are partly related to study design, study power, sample size, and different methodological criteria adopted to select participants and to measure sexual aspects. In particular, studies rarely distinguish among the different kinds of FGM and/or do not consider the impact of immigration on the perception of the quality of sexual life. In this regard, probably due to the methodological difficulty, no studies have compared the quality of sexual life before and after immigration into Western societies. Evaluating such changes may be helpful in explaining the effect of society and culture on female sexuality, including pleasure and orgasm.

Generally, most of the research literature emphasizes the negative impact of FGM on all the phases of female sexual response. For example, a recent study investigating female sexuality in Sudanese women with FGM showed a total score on the Female Sexual Function Index (FSFI) lower than the cut-off point for sexual dysfunction of the Arabic version (28.1) [40]. Although research on Egyptian women with FGM found similar FSFI results [41–44], several studies have compared the sexual function of women with different kinds of FGM, with data indicating that the severity of sexual dysfunction is linked to the severity of FGM. Clearly, type III (infibulation) and type II FGM seem to have broader impacts on female sexuality [45, 46]. From such findings, we can conclude that anatomical damage related to FGM has a role in determining the severity of sexual dysfunction [47, 48].

Interestingly, however, some studies have found that some women with FGM retain the capacity to experience pleasure and orgasm during sexual intercourse. Abdulcadir et al. [49], in a cross-sectional study comparing the sexual function and anatomy of a group of women with and without FGM, found that, despite the presence of smaller glans and clitoral body, and smaller clitoral and bulbar volumes, sexual erectile tissues responsible for sexual arousal, orgasm, and pleasure were not compromised in FGM women, making it possible for them to experience pleasure and orgasm. In line with these findings, in the case of severe forms of infibulation, the deep erectile structures and the female genital anatomy seem to be preserved, structures that could be linked with the possibility of experiencing orgasms [38]. For example, in a study by Ahmadu and colleagues, women indicated achieving orgasm exclusively by stimulating the vagina, as they considered the clitoris unimportant for female pleasure [50]. These findings suggest that the existence of vaginal orgasm (the vaginally activated orgasm or VAO, i.e., one obtained without the direct stimulation of the external clitoris, which is absent in FGM) cannot be categorically denied, and further, that orgasmic experience in women is not only driven by anatomy but also by psychological and cultural factors.

Consistent with this notion, Catania and colleagues, investigating women's beliefs and emotions related to FGM [38], found that about half (N = 57/137; 41.60%) indicated positive feelings regarding FGM (happiness, pride). In addition,

these women reported feelings of honor and heroism due to their capacity to overcome this traumatizing experience. On the other hand, the need to appear to be a "good woman" who understands her husband's need to "deflower" as a symbol of male virility may also account for some of these positive feelings [51].

Although such responses may be difficult to comprehend in Western post-feminist culture, a clinician who must deal with the sexual problems of immigrant FGM couples should be aware of such cultural attitudes and suspend judgment in order to better handle the sexual issues at hand. Immigration by FGM women from Eastern to Western society typically affects such attitudes: Morison et al. [52], for example, found that Somali women who had lived for many years in Britain had negative thoughts about FGM and were more motivated to undergo deinfibulation than younger women who had lived in the West for only several years.

Immigration to Western society exposes women to a very different cultural milieu, which often leads them to re-interpret FGM as a stigmatizing event. With a newly perceived social stigma, together with social media messaging of the violence and barbarity of FGM, these women may subsequently develop negative feelings about their bodies, which then may impact their sexual quality of life [51]. To this point, a prospective study evaluating the motivations for reconstructive surgery to reverse infibulation showed that the great majority of 453 FGM women living in Europe did so in order to restore their female identity. In contrast to authors' expectations, none of the women's motivations were related to improving sexual pleasure [53].

Such perspectives on the part of FGM women are likely due both to the absence of sexual education regarding women's sexuality and to strong sociocultural beliefs. On the one hand, these cultural beliefs seem to have a protective role regarding the female capacity to experience sexual pleasure and orgasm, but, on the other hand, they sustain the practice of FGM. The need for sexual education on the topic is critical so women come to understand the value of ending FGM practices, not just as a procedure affecting sexual pleasure, but as one that compromises women's female identity.

14.6 Why Some FGM Women Experience Sexual Pleasure and Orgasm: A Proposed Explanation

Although FGM is a painful experience leading to the development of short- and long-term complications, the sociocultural motivation encouraging women to accept FGM is often overlooked, that is, the woman's need to have an "acceptable" body that fits within the expectations of her culture. In addition, the importance of conforming to genital appearance norms and its impact on the experience of sexual pleasure has largely been neglected.

One measure of the impact of culture on the perception what is "normal," "true," and "functional" regarding one's sexuality might be provided by analyzing social media messages. In this regard, a qualitative study analyzed articles in samples of US and English media/magazines dealing with themes related to male circumcision and FGM [54]. Many of the articles viewed FGM as a surgical procedure intended to prevent women's sexual pleasure, and assumed that such women were thus

handicapped. Furthermore, information that clitoridectomy did not interfere with sexual pleasure was viewed with skepticism. In addition, the cultural belief that FGM enhances partners' sexual pleasure implied the primacy of heterosexual relationships in these articles.

Beyond the role of sociocultural factors on the experience of sexual pleasure and orgasm, human sexual response depends on the complex interaction of cognitive, relational, neurophysiological, and biochemical mechanisms [55, 56]. In this respect, the brain (rather than genitals) serves as the principal sexual organ. In fact, in contrast to men whose sexual arousal may be triggered from either central (brain) or peripheral (genital) stimulation, female sexual arousal often requires central stimulation and/or the stimulation of other (sometimes non-genital) erogenous zones [57]. In fact, specific cortical structures of paraplegic women, who may have limited or no genital sensitivity, appear to reorganize bodily erogenous zones, demonstrating brain plasticity with respect to interpretation of sexual stimulation and arousal [58]. Along similar lines, male-to-female transgender women are able to perceive, in the postoperative phase, pressure and vibration stimuli on the newly structured vagina, with the experience of orgasm in 80% of cases [59]. Nevertheless, it is also important to note that the experience of orgasm in such persons may result from other variables, such as their positive psychological adjustment, lower postoperative depression scores, and a positive disposition resulting from the gender-confirming surgery, including now having female-appearing structures such as a vulva and labia minora.

Hence, we speculate that pleasure and orgasm in women represent a subconscious reflex process, guided by the affective and emotional components of the experience, as well as by other factors such as menstrual cycle phase and hormonal status [60, 61]. Regarding cortical involvement, Tiihonen and colleagues have demonstrated that the prefrontal cortex (associated more with planning and execution than with reflex), modulated by cognitive experience, prevents arousal and progression to orgasm [62]. Hormonally, oxytocin is released during orgasm, in amounts directly proportional to its intensity [63]. Its release also occurs during stimulation of erogenous zones, during foreplay, caresses, or massages, and during the sound of a loved-one's voice [64, 65], thereby demonstrating multifactorial inputs related to female orgasm. Hence, although the experience of female pleasure and orgasm has been most strongly related to clitoral and/or vaginal stimulation, the importance of psychosocial factors in women's orgasm suggests that the erogenous inputs for women's arousal may be much broader than those for men, including a far wider array of relevant psychosocial variables.

14.7 Quality of Sexual Life after Clitoral Reconstruction

Since FGM is a practice strictly connected to women's sociocultural background, women's distress regarding their sexuality may not result from FGM per se but rather from the prejudices they encounter from peer networks and healthcare professionals. The distress from such prejudice may encourage such women to pursue

reconstructive surgery, an idea supported in part by the relatively small subpopulation of non-immigrant women with FGM requesting clitoral reconstruction in adulthood.

Studies on women with FGM pursuing clitoral reconstruction show improved capacity for clitoral orgasm after surgery, although consensus is lacking. Folde et al., for example, reported improved orgasmic capacity in women reporting orgasmic difficulty prior to reconstructive surgery. In contrast, 23% of women who frequently experienced orgasm before surgery reported a reduction in orgasmic frequency post-operatively [66]. Merckelbagh et al. found increased sexual pleasure and libido, along with a decreased dyspareunia, in women after surgery [67]. Postoperative outcomes were affected by other factors, including the type of FGM and the quality of suturing, the age at which FGM occurred, and the skill of the surgeon performing the surgery [68]. Yet, outcomes depend on more than just the technical quality of the surgery (which remains fundamental), as both preoperative sexual counseling about long-term safety and efficacy (or lack thereof) and education that sets realistic expectations after surgery, were relevant to positive outcomes. In this respect, surgical reconstruction may restore sexual functionality [69] without necessarily improving the woman's sexual experience, the latter being influenced by any number of biopsychosocial factors.

14.8 What we Know about the Management of Sexual Complications Related to FGM

Although the prevalence of FGM is high in some regions of the world despite campaigns highlighting possible health risks and costs to the healthcare system, programs for healthcare trainees and practitioners that instill appropriate knowledge, attitudes, and management practices for treatment of women with FGM are lacking [70, 71]. Training programs for FGM complications should include evidence-based information that includes not only details regarding the practice of FGM, but also the roles of health education, sexual counseling, and global care for those affected. In addition, such programs should emphasize efforts toward increased prevention and decreased medicalization of FGM, such that the clinical care of such women encompasses a broader biopsychosocial approach [70, 71].

Given the lack of training programs for the management of FGM, we propose a number of topics that might be considered as part of a clinical consultation (Table 14.2). Broadly speaking, healthcare professionals should improve their knowledge about FGM, be cognizant of their attitudes toward FGM, and investigate the woman's experience and beliefs related to FGM. As part of this process, key points (Table 14.2) would help ensure a culturally respectful therapy in dealing with sex-related issues.

- Developing an understanding of FGM would include the following: knowledge of its types; major physical complications; information about countries and religions that practice FGM; cultural reasons for genital cutting; defibulation;

Table 14.2 Key points of a culturally respectful sex therapy for FGM women (adopted and modified from [74])

Assessment of personal attitudes toward FGM • Self-reflection on personal feelings and reactions toward FGM • Acceptance of personal limitations • Judgment suspension
Improvement of knowledge about the patient's culture • Awareness of cultural differences • Adoption of a curious and respectful attitude toward the cultural beliefs promoting FGM
Improvement of knowledge about the impact culture may have on the discussion of sexual themes • Be aware of language barriers influencing therapeutic relationship • Ask the patient what kind of language is comfortable for her in discussing FGM-related problems
Clarification of culturally determined priorities in the field of sexual life • Ask the patient what the primary goal of the relationship is: passion, intimacy, commitment, reproductive needs • Abolition of sexual intercourse and sexual intimacy prior to marriage
Consideration of possible religious conflicts • Evaluation of sexual rules determined by religion (restrictions on premarital sex, masturbation, extra-vaginal ejaculation, and sexual positions and practices) • Consider modification of sex therapy in line with religious restrictions
Evaluation of a sexual problem from a sociocultural point of view • Discussion about the sexual problem, defining it based on what is culturally considered "normal"/"functional" or "abnormal"/"dysfunctional"

obstetric care in the event of FGM and reinfibulation; determinants of medicalization; medical and legal controversies regarding FGM and cosmetic surgery; medical, psychological, and surgical treatments indicated for improving girls' and women's health; and the care of children with FGM [72–74].

- Implementing awareness of personal attitudes toward FGM includes reflection on and analysis of healthcare providers' feelings about women with FGM; past clinical experiences and encounters with women with FGM; awareness of available clinical guidelines and local laws; confidence in the clinical management of women with FGM; personal opinions concerning pricking and piercing classified as FGM type IV; and attitudes concerning alternative initiation rites and the discrimination of uncut girls/women.
- Evaluating women's experiences and beliefs related to FGM requires appropriate communication language, terminology, and skills that help build trust, openness, and confidence between the practitioner and the patient.

14.9 Conclusions

FGM is a major biopsychosocial problem impacting women's general well-being. Nevertheless, literature data show discordant results regarding the impact of FGM on women's sexual life. Multiple factors come into play in the sexual experiences of women, including their country-of-origin as well as their current (Westernized)

country-of-residence, the years in the new culture, the level of perceived social stigma related to FGM, culturally determined beliefs regarding FGM, requests for a defibulation, and so on. In addition, each woman's individual (psychological) needs will differ, thereby requiring the development of individually tailored assessment and counseling that not only addresses sexual issues but also attends to her overall psychological well-being.

In contrast to FGM, although male castration for whatever reason (from choirboys to eunuchs for harems) is a procedure of bygone days, male circumcision is still largely practiced, with its medical aspects still under debate (see Chap. 17 of this book). Thus, human genital modification continues to represent a fairly widespread practice among both men and women, much of which could be culturally (and/or religiously) explained but not necessarily justified.

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Disposition and Treatment of Paraphilia in Non-western Cultures

15

George D. Zgourides

15.1 Introduction

Civilizations throughout history have developed conceptualizations of norm-appropriate sexual behaviors. Sexual beliefs, practices, values, dispositions, and opinions of normalcy often differ considerably from culture to culture [1]. "Variation" is probably the broadest term used when speaking of paraphilic behaviors, implying some degree of divergence (or "deviancy") from "normal" as defined socioculturally. Thus, variations in sexuality and loving behaviors are not always consistent with standard Western descriptions and terminologies [2]. This understandably becomes problematic when Westerners who speak English attempt to apply descriptors, inclusions, and exclusions to non-Westerners who speak other languages.

Humans are sexual from birth until death, with dynamic changes occurring throughout the lifespan. While each individual's experience of sexuality is unique, common patterns and trends in all human beings' collective experience of sexuality become apparent. The ability to interpret and understand these patterns and trends provides a more in-depth and historically accurate understanding of the human experience of sexuality in general [3–5]. Sexuality, including its many disorders and dysfunctions, is a global phenomenon and not something of exclusive interest to

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Europeans, Americans, and other Westerners [6–11]. For example, sex researchers have found premature ejaculation to be prevalent among men in Turkey [11], as well as female sexual dysfunction to be prevalent in Iran [12].

Many sexual behaviors, dispositions, and variations—some controversial—exist across cultures and societies [13, 14]. That which is considered acceptable to one group may not be to another. Examining sexuality in all of its expressions from a cross-cultural perspective highlights the relative nature of standards and customs of behavior within a system or community. Remaining alert to transcultural differences and avoiding ethnocentrism increases opportunities to decrease suspicion of others' norms and values while also challenging *sexual stereotypes*, or beliefs within a society as to how members *should* appear and behave sexually [15].

Many mistakenly use such phrases as "Western culture," "White culture," "American culture," "European culture," "Asian culture," "African culture," and so forth—as if such huge, standardized, and homogenous groupings truly exist in today's world. Potentially, this is a failure to acknowledge the presence of large-scale cultural diversity. In reality, many different cultural groups with their own norms comprise many different societies cross-nationally.

Because of a severe lack of controlled research studies into paraphilias worldwide, this chapter briefly explores and highlights alternate sexual interests and disorders from a more generalized point of view, particularly within a context of culturally bound and socio-demographic expectations and considerations whenever possible.

15.2 Perspectives in Human Sexuality

The vast majority of humans belong to one or more sociocultural systems. Of interest to sexual medicine specialists is how these different social systems interact and influence individuals, couples, and households with respect to various expressions of sexuality. The most common of these systems are family, community, work, educational, religious, and technological ones.

Children might receive conflicting or unhealthy messages about sexuality from their parents, school, and/or pornography [16]. As another potent influencer, organized religion's teachings, morals, tenets, and values can play a powerful role for life for people raised in a religious environment—be it helpful or harmful [17, 18]. One might be scolded for having "perverted thoughts" that "violate God's laws," even when the desires and behaviors are harmless, such as the case of an occasional cross-dresser or a couple who mutually agree to an alternative approach to intercourse.

Knowing which system provides what sexual message is helpful for understanding and, if necessary, challenging irrational notions. Furthermore, identifying and analyzing the role of particular cultural and social systems is basic to understanding sexual behaviors—and in the case of this chapter: paraphilias and paraphilic disorders in the context of a more comprehensive, global perspective.

15.3 Culture, Society, and Roles in Human Sexuality

Culture as a concept refers to beliefs, rules, products, and other characteristics shared ("cultural bonding") by members of a social group. Society as a concept refers to the people who interact within a common culture. Through culture and society, entities define themselves, conform to agreed-upon values, and contribute to the larger whole. Common cultural and societal institutions include family, education, work, healthcare, and organized religion—all of which claim a stake in deciding normality versus abnormality.

Sexual roles are the parts humans play in their sexual engagements within cultural and societal contexts. What is proper? What is improper? How much sexual freedom is allowed? Do sexual rubrics apply to every member of a society? Sexual roles affect every aspect of life, forming an interconnection between sexual identity, attitudes, and expressions. These are both personal and cultural, defining how persons behave sexually within the parameters of society. Sexual roles determine how sexual events will occur, and if they are culturally characterized as suitable or not.

Regarding paraphilias, sexual roles involve both imaginal and behavioral alternatives that have been acquired through whatever means. Yet enforced sexual roles can prove deleterious to self-expression. Conforming to restrictive, long-standing stereotypes leaves little room for sexual creativity or experimentation.

How are these sexual roles acquired? Learning is the foremost vehicle, especially during childhood and adolescence. Young people receive parental approval by conforming to expectations and adopting culturally accepted, conventional *sexual scripts*—all of which are repetitively reinforced via other socializing agents, such as social media and television. The learning of sexual roles almost always occurs within social and cultural contexts.

In other words, learning is crucial in forming and shaping sexual roles, beginning with early attractions and desires [19, 20]. Humans exhibit *sexual schemas*, which are deeply entrenched cognitive frameworks about personal sexuality. People make quick judgments concerning these qualities in others, often based on observations of such inconsequential items as hairstyle, clothing, and spoken cues. Added to what people perceive is what they *expect* to perceive, based on assumptions about approved sexual preferences. Sexual schemas are taught and reinforced throughout the life cycle via numerous socializing agents—parents, teachers, friends, colleagues, media, and religious leaders—and exert a tremendous effect, especially on young children. Expectations are then passed along to successive generations.

Humans are expected to live out culturally defined roles. Yet fallacy can prevail here. Simply because society defines what behaviors, perceptions, and emotions are normal and abnormal does not mean these labels are necessarily correct or desirable. In the case of paraphilias, ongoing controversy and inconsistencies exist with respect to definitions of deviant/abnormal versus non-deviant/normal given dependency on sociocultural definitions, expectations, approvals, and prohibitions [13].

The consequences of culturally bound sexual behaviors are real—economically, physically, psychologically, spiritually, and clinically. Performance anxieties, dysfunctions, and other concerns about sexual expression are assessed and managed

based on generally recognized social norms. The aim of current thinking in sexual medicine is arriving at understandings that ultimately benefit both individuals and societies, and determine whether the majority's standards related to approved sexual desires and behaviors should be imposed upon all group members.

15.4 Identity and Orientation in Human Sexuality

Whereas uncertainty concerning exactly how sexual predilections form remains, virtual unanimity exists on at least one point—sexual identity and orientation develop very early in life, and become increasingly irreversible as accumulating sexual experiences continuously reinforce sexual inclinations.

Biological, psychological, and social ("biopsychosocial") aspects regarding the formation of sexual interests are unmistakably evident—variant or not. Genetics, pre- and post-natal hormones, differences in neurological and reproductive structures, and unique socialization and conditioning patterns all likely contribute to the development of sexual attractions and behaviors, including paraphilias.

Meaning, identity, and rigid expectations would seem to interfere with sexual fulfillment, looming large in creating sexual dysfunctions, as seen, for example, in some Malay women [21]. In many cases people define their unique sexual roles in life through fantasies and behaviors. With men across the globe raised to be dominant/powerful and superior/initiating, and women raised to be passive/weak and inferior/yielding—in other words, heterosexual in a traditional sense—no wonder the penis becomes a symbol of control and power, and the vagina becomes a symbol of submission and vulnerability. Thoughts, emotions, and behaviors outside of this sexual reality, however, are immediately suspect, with those not fitting into neatly defined heterosexual packages automatically shunned and stigmatized [22].

How can societies free persons with unconventional attractions from unfair categorizing in order to lead sexually fulfilling lives? One method is to challenge traditionally defined stereotypes, roles, and expectations, including the objective of applying less Western diagnostic weight to non-Western value systems. This has been a social justice theme of modern sexologists for many years.

15.5 Deviance in Human Sexuality

Deviance—criminal or non-criminal—refers to behavior that violates social customs and norms, usually of sufficient severity to merit disapproval from a majority of society's members. As a concept deviance is complex, given that norms can vary considerably across groups, systems, times, and places [14, 23]. What one group might consider acceptable, another might consider deviant. For instance, in some regions of Africa, women are circumcised—termed *infibulation* or *clitoridectomy*. This procedure involves surgically removing a young girl's clitoris and then sewing shut her labia. In the West boys undergoing male circumcision is a conventional practice based on Judeo-Christian norms, but girls undergoing female circumcision, or *female genital mutilation* as it is sometimes referred to in mainstream America, is an unthinkable practice.

As another example, adults who are sexually attracted to children are known as *pederasts* or *pedophiles*. Pedophilia is form of child abuse when perpetrators act upon their urges, force children into sexual activity, purchase pornography that supports mistreatment of minors, and photograph or video children in sexually explicit contexts. Child sexual abuse is culturally forbidden in most parts of the globe, and is illegal everywhere in the USA.

Child sexual abuse becomes *incest* when the abuser is a relative, irrespective of blood relations. Stepparents can be arrested for incestuously molesting stepchildren. Not all societies have laws forbidding sexual activity among varying degrees of cousins.

The point here: multiple definitions and perspectives in human sexuality are possible. Not all are widely accepted or even legal depending on locale. What is considered tolerable or intolerable to one group or subgroup might not be so to another [24].

15.6 Sexual Paraphilias

Sexual fulfillment is sometimes found through imaginal and behavioral variations that depart from what are considered to be conventional and acceptable sexual outlets. *Paraphilias* (from the Greek παρά (*para*) + φιλία (*philia*), meaning "beyond love") are alternative—perhaps even dangerous and illegal—sexual fantasies and/or practices that individuals need for sexual excitement and release. That is, *paraphiles* rely on peculiar fantasies and/or practices for sexual gratification. Some paraphilias, like cross-dressing in private, are potentially harmless. Others like, molesting children or exposing one's genitals in public, are not.

Paraphilias occur globally, though just how prevalent these variations are remains elusive, given people's reluctance to report unusual sexual inclinations and acts [1, 13]. In a comparative study, East Asian sexual offenders (e.g., Korean, Japanese, Chinese) in British Columbia resembled their non-Asian Canadian counterparts in terms of sexual offenses, but did describe more paraphilic behaviors [25]. *Multiple paraphilias* are defined as three or more paraphilias—a more frequent occurrence than previously thought—that can also include concomitant substance abuse, as noted by Iranian researchers [26]. As well, 13% of male subjects in a study of paraphilic cases in Turkey were found to have more than one paraphilia [27]. Overall, more men than women report being paraphiles [28].

Sex-positive cultural paradigms tend to construe sex acts as pleasure-focused, whereas *sex-negative* cultural paradigms tend to construe sex acts as procreation-focused [29]. Egocentric/individualistic ("I-focus") paradigms tend to emphasize personal sexual goals and pursuits, whereas sociocentric/collective ("us-focus") paradigms tend to emphasize community sexual goals and pursuits. Put another way, sexually *permissive* societies are *maximal* with respect to sex ("permissive-maximal"), while sexually *repressive* societies are *minimal* with respect to sex ("repressive-minimal"). More liberally tolerant societies may have greater leniency toward sexual alternatives than more conservatively intolerant ones.

Paraphilias, therefore, pose unique challenges to historians, researchers, legislators, technicians, and clinicians as cultures and societies ultimately determine what sexual practices are acceptable versus unacceptable. Collecting epidemiological

and comparative data on paraphilias is consequently problematic. Reports of paraphilias across the globe are likely limited depending on cultural norms, privacy concerns, and personal worries about legalities. Whether non-Western individuals are hesitant to report sexual aberrations or simply lack awareness remains to be determined. Generally, disordered paraphilias come to the attention of clinicians and social researchers via legal systems.

15.6.1 Redefinitions

Hesitancy to social change seems to be a constant in today's world. In the midst of regular technological developments and breakthroughs, certain entities fear personal loss through social change, leading to vested interests (financial, moral, or otherwise) in preserving the status quo. Many people express concerns of uncertainty when attempting to adapt to ever-changing social tides.

Cultural factors can play an essential role in resisting social changes. *Cultural lag* is the delay in time that a society requires to "catch up" to cultural evolution. As one example, various organized religions (e.g., Catholic Christianity) encourage large families and regard non-procreative sexual activities that ultimately limit family size as sinful. As another example, certain groups like the Taliban of Afghanistan (in endorsing Sharia law) might even impose the death penalty on those who deviate from established religious traditions. Put another way, cultural factors as well as lag can exist between non-material culture (religious dogmas) and material culture (sexual innovations). Non-material culture inevitably must respond to innovations in material culture.

Social movements, by their very nature, question culturally established norms. In the USA today, both feminist and LGTBT (lesbian-gay-transgender-bisexual-transsexual) rights movements challenge definitions and idealizations of the "natural order" of phallocentric, patriarchal dominance—that females must acquiesce to males, that traditional, procreative heterosexuality is the only acceptable sexual standard, and that any other sexual expressions are irregular and therefore disordered. Continued resistance to sexual social movements remains predictably steadfast.

As one example of a social movement within the Western healthcare industry, the American Psychiatric Association's (APA) 2013 *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) revisited the notion of all paraphilias being abnormal, and instead distinguished between non-normative sexual interests and sexual disorders per se [28]. Proposed ICD-11 changes are promised to be similar [30]. In other words, from a clinical perspective sexual interests are not inevitably sexual disorders.

Yet such progressive thinking regarding sex has not always been the case. The history of the DSM from its first release in the 1950s (more psychodynamic and biased in approach) to the latest release in 2013 (more psychometric and neutral in approach) has been fraught with controversies, disagreements, discrepancies, and changes in sexual classifications and definitions, exemplifying how clinical and healthcare norms and values can change considerably over time given new

research data, values, and laws. Earlier versions of the DSM categorically described all sexual behaviors outside of customary Western conceptualizations of sex, including homosexuality, as abnormal and therefore disordered. With growing scientific evidence to the contrary, relaxing social mores, and humanitarian goals, the APA eventually reversed its position on homosexuality, and has continued to modify its stance on other sexual matters to improve both diagnosis and treatment, with more and more emphasis on the qualifying elements of personal distress, relationship dissatisfaction, and social dysfunction as criteria for diagnosing sexual disorders.

Western sexologists have traditionally differentiated between paraphilias that involve: (1) non-consenting partners, (2) non-human objects, and (3) suffering or humiliation. Lawyers have tended to differentiate between: (1) public indecency, (2) public lewdness, and (3) public nuisance. Criminologists have tended to differentiate between (1) consenting sex, (2) non-consenting sex, and (3) threatened sex. With so many differing perspectives and approaches to paraphilias, correlations and causations remain undetermined. For instance, having a fetish does not inevitably make one a serial rapist, although many criminals might have fetishes. Much remains to be learned in order to understand and define paraphilias within cultural contexts and their relationship to other psychosocial processes.

15.6.2 Current Classifications

The general consensus among sexologists today is that paraphilic *attractions* differ from paraphilic *disorders*, in that paraphilic disorders, to be defined as such, must create impairments in normal daily living, generate distress, prove potentially harmful to self or others, and/or be illegal.

Paraphiles often describe their sexual urges as "irresistable," "overpowering," and "overwhelming." *Egosyntonic* (consonant) paraphilic urges are those that the individual finds acceptable. *Egodystonic* (dissonant) paraphilic urges are those that the individual finds unacceptable, and these urges range from *mild* (being distressed to a slight degree by the urges) to *severe* (being distressed to a great degree by the urges, and repeatedly acting on them regardless of consequences).

Paraphilias can also have counterparts within the normal range of sexual events. As an example, it is perfectly acceptable for a couple to play with consensual bondage, or for a spouse to enjoy his or her partner wearing sexy undergarments. It is unacceptable for one member of a couple to *demand* his or her partner submit to unwelcome activities, or for a spouse to *require* his or her partner's undergarments to be present to become sexually aroused, or even worse for someone to become solely interested in bondage accouterments or undergarments instead of the partner. When sexual patterns are ongoing and disturbing, interfere significantly with one or more relationships, and/or cause legal or other problems is the person perhaps considered to be sexually disordered [24].

The aforementioned advancements in Western conceptualizations of paraphilic interests versus disorders will hopefully lead to larger societal depathologizing and destigmatizing of consensual, non-normative sexual interests and behaviors across

Table 15.1 Sexual paraphilias

Exhibitionism
Fetishism
Frotteurism
Pedophilia
Sexual masochism
Sexual sadism
Transvestism
Voyeurism

cultures [31, 32]. Winters and colleagues [33] further argue for care in applying diagnostic categories of "unspecified paraphilic disorder" (UPD) and "other specified paraphilic disorder" (OSPD), mainly to avoid unethical labeling of exotic attractions, behaviors, and syndromes.

For reference, next are very brief descriptions of the most commonly encountered sexual paraphilias ([28]; see Table 15.1), with sample non-Western references noted where appropriate.

15.6.3 Exhibitionism

Exhibitionists intentionally expose their genitals, buttocks, or breasts ("flashing") to unsuspecting and unconsenting individuals, emotionally traumatizing victims and leaving them feeling sexually violated and exploited [34]. In a study of Hong Kong undergraduates, no statistical differences were found when compared to a USA sample in terms of the incidence and nature of exhibitionism [35]. Exhibitionism no longer relies on in-person perpetration with the advent of websites and webcams.

15.6.4 Fetishism

Fetishism involves sexual attraction to inanimate objects, usually non-sexual in nature but related in some way to the human body and culture in question. While any object can be a fetish, clothes (such as bras, panties, and stockings) and accessories (such as gloves, shoes, and purses) are the most predominant. Associated with body image and fashion, uniforms are another common object fetish [36]. As well, fetish in Africa [37] and traditional foot binding in China claim long histories [38]. The typical fetishist is a male who exerts control over the fetishistic object or symbol.

15.6.5 Frotteurism

Frotteurism typically involves, for the purposes of sexual arousal, a clothed male rubbing his genitals against a clothed female in a crowded setting. Indian researcher Kalra [39] commented on a case of compulsive sexual behavior with frottage, though with depressive disorder as the perpetrator's primary complaint.

15.6.6 Pedophilia

Pedophilia is defined as sexual attraction to prepubescent children. A subcategory of pedophilia is *hebephilia*, which involves attraction to pubescent children. Sea and Beauregard [40] studied a sample of males in Korea, and found hebephilia to be a unique mix of pedophilia and *teleiophilia* (sexual attraction to adults). From pederasty in Ancient Greece [41] to ritualistic homosexual behavior among younger and older males in Sambia [42, 43], early homoerotic contact is not always predictive of later attractions and behaviors. Heterosexual relations eventually take over in many cases.

Typical pedophiles are males, though there exist reports of female teachers having sexual relations with younger male students [44]. Increasing numbers of pedophiles are seducing youth through online social media [45]. As well, pedophilia appears to be a global phenomenon, including non-Western offenders [46–48]. For instance, in Japan "JK business" promotes sexual exploitation and assault of minors [49], and child sexual abuse is stated as an increasingly prevalent problem in India [50, 51].

15.6.7 Sexual Masochism and Sexual Sadism

Sexual masochism involves sexual gratification from receiving humiliating, restraining, beating, or torturing behaviors, while sexual sadism involves perpetrating these activities [52–54]. Although separate diagnostic categories, these two paraphilias frequently occur together—known as *sadomasochism* ("S/M" or "BDSM" [*bondage-discipline sadomasochism*], [55, 56]). McCormick [55] reported on flourishing BDSM communities in South Africa. Authors Langdridge of the UK and Parchev of Israel [57] have advocated for BDSM groups to push for social and legal acceptance. Wright [32] and Cardoso [15] have also called for wider acceptance of consensual BDSM.

15.6.8 Transvestism

Transvestism is sexual gratification from dressing in clothing customarily reserved for the other gender. Reports of transvestites exist across cultures. Bristow, for example, has written about his travels across China with a transvestite from Beijing [58]. Cross-dressing in Taiwanese dramas is also well-known and considered cultural performance [59]. Transvestic disorder can progress to gender dysphoria [60].

15.6.9 Voyeurism

Voyeurism involves sexual arousal and gratification from watching or recording unsuspecting individuals who are undressing, naked, or engaging in sexual activity. The current availability of inexpensive hidden cameras has increased opportunities

for voyeuristic opportunities in locations where privacy is expected, such as public showers and locker rooms, restrooms, motel rooms, hostels, and rental units. Voyeurism is not uncommon worldwide, for example, being the most common paraphilic behavior reported in a study of English-speaking adults in a small town in South India [10]. In another study of paraphilias among young adult undergraduates at a Nigerian University, voyeurism was the most frequent paraphilia [61].

15.6.10 Other Paraphilias

A literal myriad of additional, unusual paraphilias are cited in both professional and popular literatures (see Table 15.2 for examples). Three of the more frequently of these include *necrophilia* (deceased persons), *telephone scatologia* (lewd telephone calls), and *zoophilia* (animals). Pareek [62] wrote about two notoriously famous necrophiles from modern-day India: Surendra Singh Koli and Moninder Singh Pandher. Perpetration of victims via telephone scatologia in India, Saudi Arabia, and various Arab countries can lead to multi-year imprisonment [63]. *Bestiality* has been a concern of modern mental health professionals for years [64]. Chandradasa and Champika [65] presented a case report on zoophilia in a high-functioning autistic male from Sri Lanka. The reasons for zoophilia can vary across cultures, but lack of access to human partners is one possible explanation [66, 67].

Table 15.2 Other paraphilias

Acrotomophilia (amputations)
Agalmatophilia (statues, mannequins)
Capnolagnia (smoking)
Chronophilia (specific age groups)
Coprolalia (obscene language)
Coprophilia (feces)
Dacryphilia (tears)
Emetophilia (vomit)
Gerontophilia (elderly)
Infantilism (diapers, infant-like behaviors)
Klismaphilia (enemas)
Lactophilia (breast milk)
Mazophilia (breasts)
Menophilia (menses)
Mysophilia (filth)
Narratophilia (obscene stories)
Nasophilia (noses)
Partialism (body parts)
Pictophilia (depictions, pornography)
Plushopilia (plush objects)
Trichophilia (hair)
Troilism (one's partner having sex with others)
Urophilia (urine)
Xenomelia (limb amputation or paralysis)

15.7 Dispositions and Causes of Sexual Paraphilias

Sexologists are unsure of the exact dispositions and causes responsible for paraphilias, which are presumed to arise from combinations of factors that come into play in particular ways for particular persons in particular settings. These combinations, some more prevalent at times than others, result in the different avenues of sexual expression described in this chapter. Similarities of sexual dispositions across varying groups are assumed as well, though conclusions are far from absolute given a scarcity of hard data regarding non-Western peoples.

Various biological etiologies have been offered to explain paraphilias across cultures. Certain people may be disposed, even hardwired, for paraphilias either through genetics or brain pathology [56, 68]. Research employing magnetic resonance imagery (MRI) suggests the presence of differences in brain connectivity [69], including cortical and subcortical abnormalities [70]. Neuroimaging and neuropsychological studies demonstrate structural issues in cortical circuits of the brain's right hemisphere [71]. And some men apparently have a stronger sex drive perhaps due to increased amounts of and/or sensitivity to testosterone [72, 73]; they might look for additional sexual outlets when more traditional channels are not readily available, and increased sexual reactivity might also enhance their disposition toward paraphilic interests and activities. Research from Poland and the USA does not show statistical differences between paraphilic sexual offenders and controls with respect to the interplay between neurotransmitters and genetics [74]. Medical conditions like Klinefelter syndrome and autism are sometimes associated with gender dysphoria, hypersexuality, and paraphilic disorders, as noted by researchers in Italy [75].

Male dominance in various social arenas is not without negative consequences when sexual disorders manifest. Psychologically, the disordered paraphile is often socially awkward, shy, withdrawn, repressed, confused, anxious, and angry about intimate adult relationships. Regarding the latter, hostility might play a greater role in paraphilias than other sexual interests, perhaps explaining why so much paraphilic behavior across cultures is forced on unsuspecting or unwilling victims in the form of symbolic or literal actions of sexual aggression, humiliation, power, and submission [76]. Victimization of women in Bosnia and Herzegovina through sexual assault that includes paraphilic behaviors is one of many tragic examples [77].

Conditioning likely plays a part in learning and maintaining paraphilic desires and behaviors. Repeatedly masturbating to orgasm in the context of paraphilic fantasies reinforces sexual desires and behaviors, in turn making it more difficult to interrupt patterns over time. Internet access to paraphilic and other pornographic images becomes all the more noteworthy [78]. For example, online communities of zoophiles exist for support of mutual interests as well as the promotion of this paraphilia as their sexual orientation [67].

One classic multidimensional approach to conceptualizing paraphilias is John Money's theory of "lovemaps." Money [79] stressed that sexual attractions arise from biological dispositions in combination with sources of early childhood erotic arousal that are later activated by psychosocial factors. Variations in sexuality, then, can occur at any point during development or remain latent indefinitely. "Lovemaps" as a model

explains why people from similar backgrounds do not necessarily develop similar sexual patterns; everyone develops a unique *sexual map*. The question of who develops what sexual interests and behaviors in which cultural substructure depends largely on distinct combinations of positive and negative events present in a given situation for a given person with a given biological disposition. This and similar paradigms, heavily reliant on concepts of *reward* versus *distress*, leave open the possibility of people from dissimilar cultural backgrounds developing predilections for the same sexual outlets. Nonetheless, how reward versus distress is communicated to larger groups is inherently dependent on cultural influence, with reward sometimes being at odds with societal dissonance.

15.8 Treatment of Sexual Paraphilic Disorders

Because paraphilic disorders are deeply and powerfully embedded in the psyche, treatment is difficult at best. One traditional goal in Western clinics is to replace undesirable patterns with desirable ones, always in the context of exploring the patient's thoughts, emotions, motivations, and social influences. Like other psychiatric conditions, paraphilic disorders are complex with an abundance of variables to be evaluated—the nature, severity, and history of the patient's chief complaint, personality traits and family system, motivation for treatment, relationship discord, and so forth. How such treatment and patient-practitioner interactions might play out in non-Western clinics remains to be determined.

An example of one fairly standard Western therapy for paraphilic disorders is *orgasmic reconditioning,* in which non-paraphilic objects, urges, or practices eventually replace paraphilic ones. This technique involves patients masturbating to desired paraphilic fantasies. When orgasm is inevitable during masturbation, patients switch their internal focus to non-paraphilic objects or fantasies. Orgasm occurs while thinking about non-paraphilic objects, thus reinforcing anticipated expression. Patients repeat this procedure each time during masturbation. They ultimately find non-paraphilic objects more arousing than paraphilic ones, losing interest in and abandoning dysfunctions in favor of more suitable interests [63]. How orgasmic reconditioning therapy might play out in non-Western cultures that forbid masturbation and pornography is unknown at this time due to a lack of controlled data.

15.9 Sexual Offenders

Paraphiles and others who enter the realm of sexual offense by acting on their desires have available a number of behavioral and psychiatric techniques for managing their disordered behaviors [80]. Regrettably, the long-term prognosis for perpetrators' recovery is poor, irrespective of methods used [81, 82], though not all agree with this premise [83]. Penile plethysmography, or phallometric testing, is a principal means of diagnosing and assessing treatment progress, as self-reporting by offenders is not always reliable [84, 85].

One method of dealing with sex offenders is *incarceration*, with or without the benefits of individual and/or group counseling [86]. This is perhaps the most-used approach worldwide. Another method is *castration*, involving chemical destruction (chemical castration) or surgical removal (surgical castration) of the testes. Castration is no assurance perpetrators will not sexually offend in the future, as mentioned in literature from the Republic of Macedonia [87]. Interestingly, the professional literature describes men who are sexually intrigued by the thought of being castrated [88].

Pharmaceutical treatments for disordered paraphiles often center on blocking agents and hormones to dampen perpetrators' sex drive [89, 90]. Anti-androgen agents such as medroxyprogesterone acetate (MPS) and cyproterone acetate (CPA) are commonly used, as is leuprolide acetate (LPA) [91]. Fluoxetine, a serotonin reuptake inhibitor, has also shown promise for paraphiles with concurrent symptoms of depression and anxiety [63].

Therapy of sex offenders ranges from supportive to aversive approaches. In cognitive-behavioral therapy (CBT), therapists challenge perpetrators' dysfunctional beliefs and behaviors, and formulate strategies for managing unwelcome sexual impulses. Perpetrators' early childhood development and impasses are also explored. Behavioral aversion therapy might include electrically shocking perpetrators when sexually aroused by inappropriate stimuli, such as photos of naked children. Images of consensual adult sex acts to recondition offenders follow. Participants also benefit from social skills training, couple's therapy, group therapy, and cognitive-based Rational Emotive Behavior Therapy (REBT, developed by Albert Ellis, Ph.D.) to confront irrational thinking patterns that manifest as distorted actions [92].

15.10 Cross-Cultural Influence

The problem of superimposing Western understandings of mental disorders onto non-Western cultures continues to generate controversy and disagreement [93], originating in part from earlier American and European expansionism and colonialism with consequent Western-centric labeling. Even though the DSM-5 prides itself on remaining culture- and bias-free [28], the reality of the matter is, all interpretations of mental, emotional, and behavioral phenomena are unavoidably filtered through the lens of immediate experience and sociocultural paradigms. As such, critiques of the APA and DSM-5's cultural-free claims continue [93].

A premise of this chapter is that many sexual phenomena, including paraphilias, are likely universal, at least in the sense of Western definitions. As noted above, authors in different parts of the globe have published articles looking at Western-defined paraphilias in non-Western locales. At the same time, however, some sexual phenomena seem to be culturally specific and molded. One example, though not a paraphilia per se, is *dhat*—the Indian concept of semen-loss anxiety, with resultant sexual and mental dysfunction, from cultural attitudes and expectations of masculine virility and procreative sex roles, dating back to ancient Indian Ayurvedic texts [14, 92]. Another non-paraphilic example is African "brain fag," referring to a culturally bound syndrome of cognitive, emotive, and somatic complaints [94].

Furthermore, Hinduism allows, under certain specified circumstances, a tradition of cross-dressing: males displaying feminine traits and females displaying masculine traits to foster understanding of the unique merits of both genders [23]. How are sexologists to reconcile? Unfortunately, the controlled scientific literature is sparse with respect to answering this particular question. Paraphilic or non-paraphilic, a one-size-fits-all approach likely benefits no one.

The concepts of cultural boundedness and influence are worth noting here, as features of mental health and other social events occur inside of cultural frameworks [94]. For example, dispositions and causes of paraphilias might be interpreted as either universal or culturally specific depending on people's access to the Internet, various social media platforms (e.g. Twitter, Facebook), and pornographic sites—all of these being results of growing globalization, immigration, and sexual liberation having a significant impact on actual as well as reported frequencies of the occurrence of paraphilias. The issue of changing economics, rapid industrialization, social progression, and rural versus urban development also needs to be recognized, with lower socioeconomics and rural areas perhaps preserving more folk and even superstitious models of illness and treatment [95].

Logically, cultural influence then determines how various sexual problems are handled by legal authorities and healthcare providers in different places—be it through the courts, psychotherapy, medical intervention, social stigmatization, supportive networks, and so forth. In the USA, for instance, policies related to sexual perpetration typically result in punitive actions, sexual offender registration, and social ostracization. What is not clearly known is if the same occurs in non-Western countries, given differences in degrees of sexual transgressions (e.g., voyeurism as youthful sexual curiosity versus pedophilia as sexual abuse), potentially leading to differing degrees of social interventions. Exercising caution in making blanket extrapolations is advised. What is known is Western treatments are more generally applied worldwide in cultures that both access and embrace Western information. In the absence of these formulations and values, Western terminologies, approaches, and therapies do not necessarily come to mind.

From a cross-cultural perspective, ramifications of the impact of cultural influence on patient/client–provider interactions become relative. For example, if a patient were to disclose that a physical injury resulted from a non-consensual BDSM event with his or her partner, management of this would hopefully be the same in any standard medical setting regardless of the patient's cultural identity: LGTBT, Middle Eastern, African, Asian, and so forth. In contrast, if a victim were to disclose intentional infliction of harm resulting from a consensual BDSM event, outcomes might vary widely based on cultural distinctions.

15.11 Sexual Modernity

Communal identity has long been identified as an essential influence on behavior, with a multitude of aspects of culture affecting the needs of its members through the majority's approval or disapproval.

Sexologists regularly assess a society's level of sexual awareness and proneness to approval in terms of *sexual modernity*—a measure of the readiness of organizations and institutions to offer maximal guidance for its members with respect to sex. Although cultures usually transcend national boundaries, social conditions vary substantially within countries when it comes to media access, mobility, income, employment, and other socioeconomic variables that influence sexual mores and behaviors. As knowledge and understanding of broader human sexual experiences increase, so does consumer willingness to tolerate behaviors that satisfy alternative sensory and symbolic needs. When modernity conditions are higher, functional strategies to increase awareness of sexual variants will carry the most appeal; when modernity conditions are lower, functional strategies to increase awareness of sexual variants will carry the least appeal. Measures of exposure to Western values and flexibility provide an accurate description of a nation's level of sexual modernity.

Another aspect of sexual modernity that influences behavior is exposure to assorted *sexual images, products, and services*, such as pornography, sexual toys, and prostitution. The extent to which non-Western consumers are exposed to Western, sexually oriented cultural norms could potentially influence attraction to specific sexual images, products, and services.

When cultures describe low levels of sexual modernity, members may not be familiar with the visible aspects of sexual culture or with the ability of products and services to satisfy sensory and symbolic needs. But as cultures express more modernity, exposure to expanded concepts of sexuality increases, motivating members to desire the sexual acceptance and embrace the sexual norms that they see and associate with other cultures and societies. Sexual images and products that promote group connectedness, including values of sexual self-awareness and erotic self-fulfillment, will have greater appeal in higher modernity regions. The information that members access through various media will ultimately shape their needs and attitudes regarding images and the consumption of sexual products and services.

When cultures are high in *sexual uncertainty avoidance*, risk aversion is amplified, and members become less open to novel behaviors and sexual variety, such as paraphilias. In contrast, when cultures are low in sexual uncertainty avoidance, risk aversion is lessened, and members become more open to novel behaviors and sexual variety. That is, in low uncertainty avoidance cultures, sexual imageries and actions focusing on variability, novelty, and sensory gratification are heightened.

Given powerful social effects on modernity, regional culture would be expected to have moderating effects on sexual images, products, and services. Unfortunately, cultural data concerning sexual divergences are not widely available outside of North America and Europe. Research examining the effects of modernity and subculture on alternative sexual expression should prove enlightening.

15.12 Sexual Distance and Individualism

Two additional aspects of culture potentially have a significant impact on sociosexual strategies concerning paraphilias—*sexual distance* and *sexual individualism*. *Sexual distance* is the extent to which a culture advances sexual inequality and

discrimination. Cultures high in sexual distance tend to emphasize the role of traditionally defined morals in shaping vertical relationships and boundaries across sexual categories (i.e., paraphile versus non-paraphile, heterosexual versus homosexual, pornography consumer versus non-consumer). Persons in high sexual distance/high sexual uncertainty cultures tend to be avoidant, resistant to change and variety seeking, disinclined to risk, and intolerant of ambiguity.

Put another way, cultures with high sexual distance and low sexual individualism, where people are customarily focused on sexually exclusive roles and group affiliations, often define the social, symbolic, sensory, and experiential aspects of sexual variants as unacceptable. Cultures with low sexual distance and high sexual individualism, where people are not customarily focused on sexually exclusive roles and group affiliations, often define the social, symbolic, sensory, and experiential aspects of sexual variants as acceptable.

15.13 Awareness to Acceptance

Today's sexologists strive to bring deeper awareness to and acceptance of the global vastness of human sexual expression. Cultural sensitivity to others' norms, values, mores, attitudes, customs, practices, taboos, folklore, and folkways requires knowledge of others' cultural influences and social structures. Of course, researchers continue to elucidate *cultural universals*—elements common to all cultures—to heighten sensitivity. Languages, dialects, foods, laws, and religious institutions all represent typical geo-demographic and geo-psychographic features. But these are general rather than specific area-based targets. For example, all people drink fluids of one type or another. But some drink alcohol, while others do not. What is accepted as "normal" may vary considerably from within and without; that is, normalcy is difficult to identify, define, and integrate. This leaves much room for misunderstandings, discrimination, and rejection—all too common outcomes when it comes to diverse modes of sexual expression.

Conventional efforts to eliminate intolerance are often too simplistic for such complex phenomena as paraphilias. To promote acceptance of human sexuality in the fullest sense—avant-garde or not, experts should focus energy on producing integrative methods that reduce ethnocentrism and transcultural judgments. *Cultural relativism*, or the view that one group should be evaluated according to its own standards and not those of another group, is helpful when considering sexual phenomena. Sexologists point out that there really are no good or bad cultures—just different cultures in terms of the specifics. This leads to an improved understanding of others' standards because one's own standards are not automatically assumed to be somehow better.

15.14 Opportunities and Directions

Sexuality in all of its forms is both subtle and complex. All societies obviously have sexual norms, even if not agreeable to all members. Most people desire authoritative guidance, at least to some extent, when it comes to sexual matters. In today's world

this translates into sexual laws and mores, with issues of individual privacy versus the common good determining specifics. Depending on the interpretations of these issues and laws, approval or disapproval of sexual behaviors will be more or less prohibitive.

Cultures clearly have a stake in determining the correctness or incorrectness of various sexual activities. Coercing or forcing individuals into sexual behaviors in which they do not want to engage, or for which they cannot make informed decisions due to incapacity or age, is certainly criminal. Tempting or seducing individuals into sexual behaviors, for which there is hesitancy but consent, is a gray area in which the need for social standards is less defined.

Only when members of societies organize collectively to enact change does lasting social communication and transformation occur. Sociocultural movements can dramatically shape the direction of shared thought. When activists and visionaries transcend conventional confines, they bring about momentous shifts in policies and structures.

As societies inevitably define what is lawful/desirable versus unlawful/undesirable, and because reporting of variant behaviors is directly affected by cultural directives, the collection of reliable data into the prevalence, disposition, and treatment of paraphilias, even under the most sexually liberal of situations, remains problematic and ambiguous. The subsequent virtual dearth of valid and generalizable scientific information about paraphilic desires and disorders is an invitation to sexologists worldwide to advance research in this important clinical area.

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Disability and Sexuality

16

Kate Welsh

16.1 Introduction

Disability does not discriminate. Disability is found all across the world in all cultures, times, spaces, and places. However, societies treat people with disability differently; some societies hold them in high esteem comparable to a deity while others actively exclude and/or reject them. In *Past and Present Perceptions toward Disability*, Chomba Wa Munyi describes how different cultures throughout time and place have treated people with disabilities [1]. Munyi "focused on cross-cultural factors that influence the development of perceptions toward children and adults with disabilities. Societal attitudes are significant since they determine to a large degree the extent to which the personal, social, educational, and psychological needs of persons with disabilities will be realized" [1]. Anthropologists, for example, have determined that disability was often seen as a bodily form of evil by some cultures while other cultures have seen disability as a means to pacify evil spirits [1]. In the early twentieth century in Ghana, people with developmental disabilities "were believed to be the reincarnation of a deity. Hence, they were treated with great kindness, gentleness, and patience" [1]. In ancient Greece, different approaches were evident: Spartans were ruthless and "ableism"—the discrimination and oppression of people with disabilities—was rampant throughout their society, with a person's worth based on capacity to serve in the military. In contrast, in Athens people with disabilities were pitied and afforded such amenities as state support and pensions [1].

With the rise of capitalism, globalization, neoliberalism, productivity-focused societies, and industrialization, disability has become synonymous with "a lack of contributing to society," being a burden, and/or generally being "less than" other

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people. Media, government, healthcare, education, social services, and policies in general are ableist and contribute to the exclusion of people with disabilities.

This chapter is written from the perspective of a disabled white settler, queer cis woman, an activist, artist, and educator who has firsthand experience with ableism and queer-phobia and whose intersectionalities, privileges, and experiences—including growing up in the USA and now living in Canada—inform life and interpretation. The chapter is not intended to be a comprehensive review of the topic, but rather a selective discussion of challenges faced by people with disabilities that are likely to inform patient–practitioner interactions.

According to the Canadian Survey on Disability, 2017, approximately 20% of the population has a disability [2]. In the USA the numbers are similar, with the 2012 analysis of the census reporting that "Approximately 56.7 million people (18.7%) of the 303.9 million in the civilian noninstitutionalized population had a disability in 2010"; however, 0.7% of that population (2.3 million of 324.2 million) is incarcerated, and a higher percentage of people with disabilities are represented in incarcerated populations. It is important to be culturally aware and sensitive to people with disabilities as they represent the largest minority population and, as the population ages, the number of people with disabilities will continue to grow.

[3]

16.2 Terminology

An important first step toward understanding people with disabilities is understanding terminology and labels.

16.2.1 Disability

When talking about disability, there is no ultimate definition or finite list of disabilities. Disability is a way to categorize people who have lived experiences of bodily difference. Historically, disability has been used synonymously with impairment or inability. However within this chapter we reflect on why it is important to not have a definition of disability and to not compile lists of diagnoses or categories. The Stanford Encyclopedia of Philosophy states "disability looks much like sex or race as a philosophical topic. It concerns the classification of people on the basis of observed or inferred characteristics. It raises difficult threshold questions about the extent to which the classification is based on biology or is socially constructed" [4].

Although "disability" itself is a contested term, being diagnosed and labeled as disabled in our society may hold value, especially when the label gives access to support systems. Financial support, educational support, employment accommodation, and housing are examples of assistance where medical professionals act as gatekeepers, as a physician's endorsement is necessary to "prove" disability. Conversely, some people may choose not to disclose a disability because of the stigma and fear of material consequence, such as not getting a job.

"Disability" is currently the most acceptable term to use. Some people prefer the person-first language of "people with disabilities" while others prefer identity-first language of "disabled person." Throughout this chapter, both are used interchangeably. However, it is best to ask people their preference or to match their language as they talk about themselves.

16.2.2 D/Deaf

There are two distinct definitions for the word deaf. If spelled with an uppercase D-Deaf, it refers to someone who identifies as being culturally Deaf (and uses American Sign Language [ASL] or another signed language to communicate), whereas lowercase d-deaf refers to a person with hearing loss. Deaf culture has a unique language, set of social norms, and heritage. Gallaudet University is an officially bilingual university in Washington, D.C., with the main languages being American Sign Language and English.

"American Deaf culture centers on the use of ASL and identification and unity with other people who are Deaf. A definition of the American Deaf culture that includes a set of learned behaviors of a group of people who are deaf and who have their own language (ASL), values, rules, and traditions was developed by Kannapel, a Deaf sociolinguist" [5]. *Deaf Culture: Competencies and Best Practices,* a paper written by a nurse practitioner, states, "To successfully navigate in the hearing world, deaf individuals must be able to read and write to bridge the gap when others do not know American Sign Language. Unfortunately, 90% of deaf children are born to hearing parents and do not develop language skills early on, which negatively impacts their ability to access health information and healthcare. Healthcare providers must ensure they provide culturally competent care and their practices accommodate the needs of deaf patients to mitigate communication barriers and ensure equitable care with positive health outcomes" [6].

Many D/deaf people use ASL-English interpreters to navigate the hearing world, which allows them to communicate in their preferred language of ASL. Additionally, "to successfully navigate in the hearing world, deaf individuals must be able to read and write the native language of the region to bridge the gap when others do not know American Sign Language" [6]. Some people with milder forms of hearing loss, or who communicate orally and by relying on their residual hearing, may identify as Hard of Hearing [7]. Some D/deaf people identify with being disabled but many do not.

16.2.3 Handicap

There are many theories and stories about the origin of the word "handicapped." Some argue the term was originally used to describe disabled people, post-war, that were begging on the streets in the UK with a "cap in hand." However, the Oxford English Dictionary indicates that the term was first used in the mid-1800s in sports to describe a temporary disadvantage, specifically with regard to horse racing. Throughout the early 1900s, the term handicapped started appearing in texts to describe individuals as "defective" [8]. Throughout the twentieth century, handicap became the widespread term used to label people with disabilities; its use was especially prominent with the increase of eugenics of disabled people. "Many disability rights advocates hate the term "handicap" [9]. Handicap is generally not an acceptable term any longer and should be replaced with "accessible," for example: the *accessible* parking spot, an *accessible* bathroom, etc.

16.2.4 Crip

Crip is the short form for the word Cripple. "The Anglo-Saxon words 'cripple' (crypel) and 'lame' (lam) date back to the early 9th century. Neither words were used abusively until the 17th century in the so-called age of enlightenment, when the UK led the world in slavery" [10]. The transition to using cripple as an offensive word occurred in conjunction with the dehumanization of people perceived as different or lesser. Cripple is generally not an acceptable term, although some disability rights activists have reclaimed the word Crip, using it only as a self-identifier and not in identifying other people.

Several prominent Crip activists include:

- Sins Invalid, "a performance project on disability and sexuality that incubates and celebrates artists with disabilities, centralizing artists of color and queer and gender-variant artists as communities who have been historically marginalized from social discourse" [11]. Sins Invalid coined the term disability justice. "Disability justice is a multi-issue political understanding of disability and ableism, moving away from a rights based equality model and beyond just access, to a framework that centers on justice and wholeness for all disabled people and communities" [12].
- Mia Mingus, writer and community organizer for disability justice.
- Sarah Jama, founder of Ontario Disability Justice Network djno.org

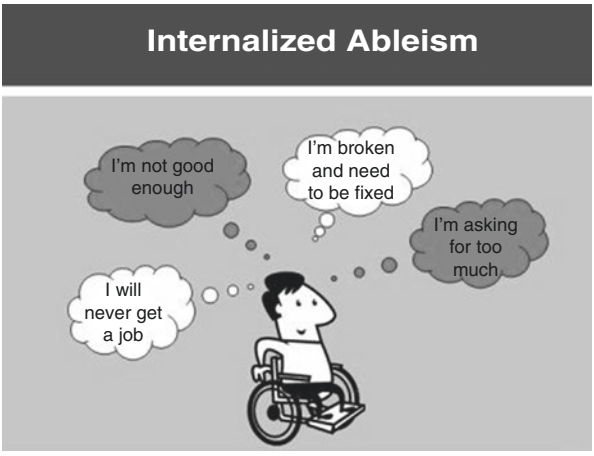
16.2.5 Ableism

Ableism is a form of discrimination and oppression. It is "the practices and dominant attitudes in society that devalue and limit the potential of persons with disabilities. A set of practices and beliefs that assign inferior value (worth) to people who have developmental, emotional, physical or psychiatric disabilities" [13]. Ableism is rampant

throughout all parts of society and perpetrated by the media and social institutions. Parsons et al. explain, "[i]ndividuals with disabilities are largely ignored by mainstream media. When shown they are often shown as dependent and asexual" [14].

Medical Ableism occurs when doctors, nurses, administrators, and other healthcare professionals treat people with disabilities as inferior and invisible, and devalue their worth, potentialities, and bodily autonomy. Medical ableism can also exist within the physical environments of healthcare settings, such as a sexual health clinic not having a Hoyer lift that may be needed to perform an external visual exam or swab on someone with physical differences. Since the medical model of disability is the dominant model, often the medical system may be an individual's first encounter with the label of disability. This first encounter may play a critical role in how individuals see their own disability. Healthcare providers may inadvertently shape a person's self-worth if they imply that the disability diagnosis is hopeless, negatively life altering, or catastrophic, or if they are non-encouraging in their approach. The healthcare system often focuses on cures and quick fixes, which are sometimes out of reach for people with disabilities and chronic health conditions. Also the need to cure or fix disability is problematic in itself as it assumes that people with disabilities cannot be happy and live fulfilling lives in their current condition.

Medical ableism, combined with other forms of societal ableism, can lead to "internalized ableism." Internalized ableism occurs when people living with a disability feel bad about themselves, and hold the belief that they are inherently less worthy or valuable than their able-bodied peers. This low self-esteem can lead to many negative health outcomes, with many people with disabilities avoiding doctors or health professionals in order to avoid medical ableism. Internalized ableism can also lead disabled people to compare their worth to other disabled people and create negative competition between them (see cartoon below).



[15]

Maria R. Palacios, a poet, author, disability advocate, spoken word performer, disability educator, workshop facilitator, and professional presenter uses words to

empower and educate. Her poem on internalized ableism exemplifies the intensity it can have on people's lives as seen in this excerpt [15].

The Other Side of Ableism
By Maria R. Palacios
Internalized ableism is
believing that our bodies
are incapable of pleasure,
allowing others to define how we should define
pleasure
because many people believe
broken bodies don't feel
broken bodies don't give,
broken minds don't understand
Love,
intimacy
sensuality
Internalized ableism is
denying our own sexuality,
or turning able-bodied lovers into heroes for sleeping with us
because sex with a disabled person is some sort of sacrifice,
something that deserves respect
or an Amen
because sex with a cripple is got to earn you some heaven brownie points
even at the risk of sin.

To read the whole poem: go to: https://cripstory.wordpress.com/2017/07/06/the-other-side-of-ableism/.

16.3 Approaches Toward and Categories of Disabilities

16.3.1 Medical Model of Disability

The medical model of disability views impairment of the individual as the problem. Disability is something to cure, fix, hide, or manage. This model has its roots in the biomedical model of the body and links diagnosis to disability, with a need to fix it in order to fit into "normative" ideals.

16.3.2 Social Model of Disability

Disabled activists created the social model of disability as a theory of disability in the 1980s in the UK. The social model focuses on barriers created by society, both physical and attitudinal, that contribute to the disability of people with bodily

differences. This model "focuses on the concept that disability is not an individual possessive trait but rather an external socially mediated phenomenon, which can be challenged and changed" [16].

Below is a cartoon that visually explains the main difference between the medical and social models of disability. Often the fixes to society's barriers that remedy the exclusion they create for people with disabilities result in better access for all individuals and do not have to be seen as a fix that is solely for the use of people with disabilities but one that can be used by everyone. A ramp, for example, can be used by people in wheelchairs, as well as people who would otherwise walk upstairs. Disability scholars prefer to refer to disabilities as a combination of physical difference and societal barriers. Societal barriers lead to disability; disability is a result of societal barriers.

[17]

16.3.3 Categories of Disability

Most disability scholars reject the ways in which society categorizes disability, focusing on the medicalization and diagnosing of individuals. But because the readership of this text includes a medical audience, some of the more generalized categories of disability are listed here because disability is often only seen in terms of physical, visible differences, whereas many other kinds of diagnoses and experiences can also be part of a disability categorization. These categories may overlap and people may fall into multiple disability categorizations. The disability may be present from birth, develop in life, be caused by an injury or accident, or a result from aging or inadequate care.

- Episodic Disabilities
- Intelectual and Developmental (IDD)
- Invisible
- Mobility/Physical

- Psychiatric/Mental Health
- Sensory

16.4 Intersectionality

Kimberle Crenshaw, a black feminist scholar, coined the term "intersectionality" in 1989. Intersectionality "has become the predominant way of conceptualizing the relation between systems of oppression which construct our multiple identities and our social locations in hierarchies of power and privilege" [18]. In particular, Crenshaw created the term intersectionality as a metaphor to explain the multiplicity of oppression; she did not just experience sexism alone or racism alone but rather these forms of oppression interlocked and worked together.

When acknowledging the oppressions that disabled people face, an understanding of intersectionality is important. Disabled people have multiple identities and may face discrimination differently than other people. The Magic Wand, a poem by Lynn Manning, a Black blind man, addresses the intersectionality of disability and race.

The Magic Wand
A poem by Lynn Manning
Quick-change artist extraordinaire,
I whip out my folded cane
and change from Black Man to 'blind man'
with a flick of my wrist.
It is a profound metamorphosis –
From God-gifted wizard of round ball
Dominating backboards across America
To God-gifted idiot savant
Pounding out chart busters on a cocked-eyed whim;
From sociopathic gangbanger with death for eyes
To all-seeing soul with saintly spirit;
From rape deranged misogynist
To poor motherless child;
From welfare rich pimp
To disability rich gimp;
And from white Man's burden
To every man's burden.
It is always a profound metamorphosis –
Whether from cursed by man to cursed by God,
Or from scripture condemned to God ordained.
My final form is never of my choosing;
I only wield the wand;
You are the magician.

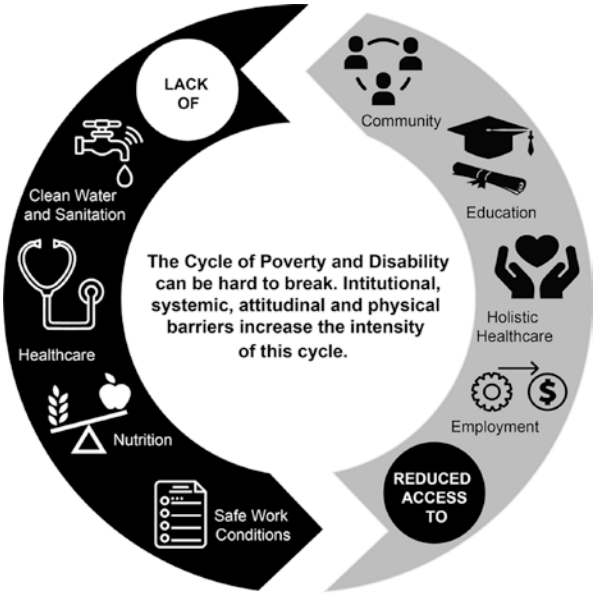
[19]

Parsons, Reichl, and Pedersen address the intersectionality of women with disabilities: "women with disabilities are marginalized both because of their status as disabled and also because of their gender. The cross section of discrimination based on both disability and gender has serious implications for women with disabilities in that they are effectively rendered powerless by society" [14]. Women with disabilities are many times more likely to be victims of sexual violence than able-bodied women (see Sexual Violence section below).

16.5 Healthcare Issues

16.5.1 Disability-Poverty Cycle

Poverty can lead to disability and disability can lead to poverty, a cycle that is hard to break. Poverty leads to disability through lack of proper housing, nutritious food and clean water, and access to consistent healthcare. Disability contributes to or increases poverty levels due to discrimination and barriers that lead to less access to education, proper housing, and employment opportunities, along with increased social isolation. According to the 2017 Canadian Survey on Disability "The highest rates of poverty (for those aged 15 to 64 years) were among those with more severe disabilities who were living alone…6 in 10 were below the poverty line" [20]. According to a 2012 report on the 2010 US Census, "[j]ust as earnings and income were lower for people with disabilities, poverty rates were higher. Approximately 28.6% of people aged 15–64 with disabilities were in poverty [compared to] 14.3% of people with no disability" [21].



[3]

16.5.2 Lack of Care

Often people with disabilities are less likely to be taken seriously when receiving health care. Unfortunately, medical professionals sometimes assume they know more about a disabled person's body than the person him/herself. In addition, ailments may be overlooked or considered symptoms of one's disability rather than viewed as a legitimate concern. For example, someone who has a physical disability may be ignored when reporting symptoms of anxiety, as the physical disability is seen as a bigger "issue" than the mental health concern. People with disabilities may be denied some forms of health care because of their disability, for example, contraception or STI testing. Healthcare providers often assume they know what is best for their patient rather than listening to the wants and needs of the person. This is particularly the case for transgender people with disabilities who may be denied access to gender transition-related care because of their disability. In the article *Navigating the Twists and Turns of Healthcare as a Trans Disabled Person*, the author interviews several trans-disabled people, one of whom remarks, "There's just the CONSTANT tension of like, you can find transition-related healthcare that is clueless about your disabilities, or you can find healthcare treating your disabilities that is clueless about trans identities" [22].

16.5.3 Language and Communication

A Deaf person may request an ASL interpreter to ensure clear communication between the individual and the healthcare worker. The Deaf person's preferences regarding the choice of interpreter need to be considered and the interpreter needs to be knowledgeable and competent in interpreting topics related to sexual health. Interpreters should be trained professionals who are members of their professional association and therefore bound by a code of ethics, including the requirement to keep all information confidential. As such, the client/healthcare provider relationship should not be impacted by the presence of an interpreter beyond the role of facilitating communication. The National Association of the Deaf reminds us, "service providers may mistake cultural, language and communication issues for developmental delays or mental illness" [23]. If an interpreter is not available, the healthcare provider may be able to use other ways to communicate such as by texting, realizing such communication is in a language (e.g., English) which may not be the Deaf person's primary language (e.g., ASL).

Some people with disabilities have advocates that translate their speaking so that healthcare workers can understand them; this individual may be a personal support worker or another caregiver, a Deaf/Blind intervener, or an advocate who attends appointments with the person with the disability. Depending on the relationship between the person with a disability and the advocate, sensitive topics such as sexuality, sexual practices, and healthcare questions may be avoided due to awkwardness or the desire to maintain a positive relationship. Such avoidance may be

especially likely if the advocate is a parent or has a certain level of power over the person with a disability. See the following section on "Caregivers and Power Dynamics."

Several alternative types of communication include:

- Communication boards (manual or electronic) which involve pointing to words or pictures to communicate.
- Text-to-Speech devices.
- Tactile ASL or Hand-over-Hand ASL (for Deaf-Blind people who prefer to communicate using ASL).
- Speech Reading.
- Print on Palm, in which the person communicating with the deaf-blind person prints large block letters on the other person's palm. Each letter is written in the same location on the person's palm. This is frequently how deaf-blind people communicate with the public.

There are many other forms of communication and, as culture and technologies develop, communication options will also continue to develop.

16.5.4 Caregivers and Power Dynamics

Since many people with disabilities rely on others to help with daily living tasks, depending on the nature of their disability, these caregivers hold power over them. Often caregivers are parents or other family members, or in some cases personal support workers or other paid staff. Caregivers may have predetermined hopes and dreams for their loved one or, conversely, they may have already assumed how their life will play out. Often these assumptions are rooted in ableism, involve power dynamics, and may originate from the media or public institutions. In addition, not being able to speak for oneself, having one's needs seen as part of a disability and thus invalidated, and the assumption of lack of agency by caregivers not only close off opportunities for people with disabilities but may lead to questioning their judgments in ways that would never occur for able-bodied persons.

16.6 Issues Surrounding Sexuality

A 2010 research study that aimed to "describe the current societal perceptions and attitudes surrounding sexuality and disability" found five main attitudes regarding sexuality: asexuality/stigmatization, heteronormative ideas of sex and naturalness, lack of emphasis on sexual rights, lack of information and sex education, and visible versus invisible disabilities. Asexuality is a spectrum where the person may not feel any sexual desires or have any wish to pursue sexual activities. "Heternormativity" is the idea that being heterosexual is the natural and "right" way to be, including the

belief that sex should include penis/vaginal intercourse. People with disabilities face countless barriers to sexual expression and sexual fulfillment within ableist cultures [24].

16.6.1 Sexuality

People with disabilities have the same range of sexuality/sexual interests as able-bodied people. However people with disabilities are more often seen as asexual or are infantilized. Kaufman, Silverberg, and Odette debunk common myths about people with disabilities and sex. Specifically, the myth that all disabled people are asexual comes from the idea that people with disabilities are helpless, like children. As the authors argue, "If you can't feed yourself or need help wiping your ass, or need help getting in and out of a car, you are considered a child. Thus they (society-author's note) deny our sexualities" [25]. Since this myth is prevalent and people with disabilities are often at the whim of caregivers or parents, sexuality or sexual expression may not be expressed until much later than for peers. People with disabilities are often actively denied access to their own sexuality, as it is not seen as part of the human needs for living well. Disabled people are often not seen as desirable, as they fall victim to the same stereotypes about sex that other people do, namely, that sex has to be spontaneous and is only for attractive young able-bodied people. Esmail et al. explain, "individuals with disabilities are commonly viewed as asexual due to a predominant heteronormative idea of sex and what is considered natural. A lack of information and education on sexuality and disability was a major contributing factor toward the stigma attached to disability and sexuality" [26].

16.6.2 Body Image

Internalized ableism affects negative body image as well as all the other forms of discrimination and oppression. People with disabilities have complicated relationships with their bodies that are often shaped by medicalization, sexual violence, ableism, less access to education, lack of autonomy, and bodies as sites of many kinds of trauma. Since sex is often a physical act (although phone sex or sexting can be forms of sex as well), the complicated relationship persons with disabilities have with their bodies leads to complicated relationships regarding sex.

16.6.3 Lack of Information and Sex Education

Sex education, when it does occur in school systems, is often connected to physical education (PE) or gym classes. Since many people with disabilities are excluded from PE classes, they may be excluded from sex education, even when they are a part of the "regular" education curriculum. In addition, students in "special

education" programs for individuals who are developmentally delayed are often excluded from the sex education curriculum. This situation often occurs not because these students do not need this information but because parents and teachers may be uncomfortable with the idea that persons with disabilities also have sexual needs. Furthermore, when students with disabilities are included in a classroom where sex education is taught, they may find the information useless or not relatable because disabled people are not represented in the curriculum.

Case Study

"I did not have sex ed classes consistently until graduation, but when I did I was not deliberately excluded. That being said, the focus was on discussions of heterosexual sex and issues related to it so I never felt that I was learning anything, which could be applied, to my life. That is to say nothing of the fact that all of the discussions…focused on nondisabled bodies. Lastly, right from the get go in seventh grade when sex ed began, it felt like my presence in the class was mandatory but that any opinions or questions I might have were generally ignored, maybe owing to the fact that the teacher assumed sex would not be a part of my life at any point."

– undergraduate student with disabilities

16.6.4 Sexual Violence

People with disabilities report higher rates of sexual violence than people without disabilities. According to a Stats Canada's 2014 report, "Women with a mental health-related disability (131 per 1000) or a cognitive disability (121 per 1000) were more likely to report having been a victim of sexual assault, compared with women without a disability (29 per 1000)" [27]. In this regard, Kaufman et al. state it is "clear that there is a much higher than average risk of sexual abuse for people living with disabilities. The numbers from different studies vary, but the risk for women with disabilities is anywhere from two to ten times greater than that found in the general population. The risk is higher for men as well, but reliable information is even more scarce than for women" [25]. It is also noteworthy that many people with disabilities cannot report sexual violence, as their caregiver may be the person abusing them.

16.6.5 Social Isolation

Ableism, and how society creates and maintains barriers for people with disabilities to connect, can lead to social isolation. Not only is access to other disabled people limited, but institutional, environmental, and social barriers lead to isolation from most forms of social interactions. One research study on disability, social isolation, and loneliness found that "61% of disabled participants acknowledged that they spent most of their time alone, compared with 28% of the nondisabled group" [28].

The internet and social media in particular have played a big role in reducing isolation for many people with disabilities. Additionally, dating apps have been beneficial for meeting others without the barrier of having to meet initially in a physical space.

16.6.6 Sex Workers

Sex work and the sex industry can be a valuable avenue for sexual fulfillment for people with disabilities. However disabled people also face "substantial barriers as clients trying to access sex, sexual services and support" [29]. Criminalization and stigmatization of sex work and hiring sex workers has a negative impact on sex workers and clients with disabilities.

It is also notable that due to the nature of sex work, a large percentage of sex workers have disabilities, in particular, invisible ones [29]. Sex work can be flexible and has relatively high pay for a minimal amount of hours, which makes this type of work ideal for some people with disabilities. One Canadian dominatrix reports, "the sex industry has provided the necessary means to support herself," providing an example of the resiliency that people with disabilities show when finding work that they have control over [29].

16.7 Practical Implications for Healthcare Providers

Understanding the issues people with disabilities face will help healthcare providers take a more patient-centered approach to working with such individuals. Health providers need to become allies to people with disabilities, as people with disabilities need the support and advocacy of their healthcare providers in order to gain access to health care in general and sexual health care in particular. Having open and honest discussions—including recognizing one's potential biases and limited knowledge—helps build needed trust.

16.7.1 Commitment to Respect and Dignity

One of the core elements of inclusion and disability justice is respect and dignity. Healthcare providers should listen carefully to their clients/patients, take their word as truth, not interrupt, and especially important, not make assumptions regarding disability and sexuality. People with disabilities do have sex, although it might not conform to traditional expectations and may extend substantially beyond the more traditional repertoire of sexual activities. The healthcare provider should also consider—and staff should be informed—that booking additional time might be beneficial, especially if the person's communication style takes longer (see previous section on Communication).

16.7.2 Understanding the Possible Need for Planning Sex and Using Sex Toys

Sex toys, vibrators, and props/pillows can be very helpful to enhance pleasure, especially for people with disabilities who may have weak motor skills or range of motion. Additionally, sex is often thought of as spontaneous, but planning can be very useful and help people with disabilities fulfill their desires. Healthcare providers can show support by encouraging their clients to plan their sex, map out their own desires, and learn to talk about what they want and how to make it happen with their partner(s).

Case Study
As a queer disabled person, I love planning and scheduling my sex. It makes the act of sex seem that much more purposeful and important to me. I used to crave these able-bodied notions of spontaneity, but very quickly realized that planning makes sex better. It allows me to have agency of my experience, and I get excited when I can write down in my day planner, that on this day I get to have sex. Planning sex allows for me to work with attendant care so that I can feel fresh, vibrant and sexy prior to the hook up, and that gives me a confidence spontaneity never could.—Andrew Gurza, creator of podcast *Disability After Dark*

16.7.3 Honoring the Resilience and Creativity of Persons with Disabilities

Disability can lead people to become expertly resilient and the healthcare provider should honor this capacity, encouraging persons with disabilities to formulate their own solutions and recognizing these strengths without being patronizing.

16.7.4 Taking the Time to Learn a Little Bit More

Many resources discuss specific disabilities and sexuality. The healthcare provider can better advise clients with disabilities regarding sexual issues/treatments by consulting the following:

1. *The Ultimate Guide to Sex and Disability*, by Miriam Kaufman [25]. This book, written by a medical doctor, a sex educator, and a disability activist, is an open and honest how-to focused book. The book includes disability-specific sections as well as encouragement, support, information, and advice about all things related to sex and disability. Although the book's audience is people with disabilities, it could also be useful for healthcare professionals.

2. *Sexuality and Disability: A guide for everyday practice*, by [30]. Abingdon: Radcliffe Medical Press. This book's audience is healthcare practitioners and social workers and includes diagnoses, specific treatments, and advice for people who may feel uneasy addressing topics of sexuality with their clients.
3. Communication advice: This URL from the National League for Nursing provides a wealth of information regarding communicating with persons having disabilities, both generally and for specific disabilities. It also provides links to other useful resources. http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/communicating-with-people-with-disabilities.

16.8 Summary

People with disabilities face many challenges in their everyday lives. Healthcare providers should be aware not only of these challenges, but also of their own cultural biases—reflected in ableism—that may affect their assumptions and interactions with this population of clients. Medical ableism can lead to distrust of healthcare providers by the disabled, and result in a lack of care-seeking within this population. Intersectionality needs to be recognized, along with the fact that sexual fulfillment for people with disabilities is often negatively impacted by mitigating experiences such as poor body image, lack of sex education, and higher rates of sexual violence and social isolation. Specifically, healthcare providers should not add to the challenges of disabled persons, but rather should become their allies in achieving a healthy and satisfying sex life to the extent that clients seek such assistance, as those with disabilities have a right to bias-free and adequate healthcare, as well as acceptance—and guidance when appropriate—in the expression of their sexuality.

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Sexual Surgery Through the Ages, in Varying Cultures

17

Jelto J. Drenth

17.1 Introduction

Genital surgery is a topic strongly influenced by cultural forces, both across time and geographic region, with religion, gender scripts, and tradition playing key roles. Medical science is not immune from cultural influences, and genital surgical interventions are often inspired by emotion. Regarding approaches to each gender, convictions may overrule science.

In this chapter, we discuss surgical operations, once considered *good practice,* that seem appalling in retrospect. We hope reflection on the role that contemporary culture, beliefs, and attitudes play in medical practice will induce modesty and humility in students and practitioners of medicine–awareness that sociocultural norms not only shape our acceptance and rejection of certain medical interventions but that the practices we endorse in today's culture may one day be considered inappropriate or barbaric. The overview focuses on female and male genital surgery as *medical interventions* as well the medical/social forces and beliefs that gave rise to them; the chapter does not include discussion of ritual circumcisions prescribed by religious groups, as these fall outside the scope of medical intervention.

The chapter proceeds from female to male: In the era that ancient barber-surgery practices flowered into a prestigious branch of medical science, clitoridectomy was propagated for female pathologies such as hysteria, menstrual discomfort, and unexplained abdominal complaints. Not long after, circumcision was promulgated as both a cure and prevention for various ailments in males, with many penile surgical procedures persisting even today in attempts to create a "better" functioning penis. The final section provides reflection on the cultural changes over time that have relegated some procedures to the past, and cultural changes over place that result in differences in acceptability of genital surgery even today.

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17.2 Historical and Current Perspectives on Genital Surgery in Women

17.2.1 Surgery on Female Genitalia: Controlling Un-womanly Behavior

For twenty-first century physicians, *clitoridectomy* is a "savage" tribal genital mutilation, to be eradicated as soon as possible, but in the first half of the nineteenth century this intervention was introduced as treatment for nymphomania and excessive masturbation, and gradually for a wide range of female ailments, popularly qualified as hysteria [1]. Britain's most prestigious gynecologist, Isaac Baker Brown, co-founder of St Mary's Hospital and president of the Medical Society of London, published *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females* (1886), an enthusiastic polemic in favor of clitoridectomy [2]. Baker Brown was inspired by the then popular physiological theory of the nervous system: If the mind is in total confusion, the cause may lie in "peripheral irritation," and these conditions would progress unstoppably toward the woman's total deterioration. The range of ailments that, according to Baker Brown, could be assumed under the heading of "hysteria" was extremely wide, so drastic measures were indicated. The clitoris was simply cut off with scissors and the wound left to heal under a T-bandage. Patients nearly always left the Surgical Home 2–3 weeks later, having been pronounced "cured," implying they had re-adjusted to their decent roles as housewives.

Baker Brown's colleagues were not convinced and exposed him as a hypocrite. He had concealed the true nature of "peripheral irritation": clitoridectomy was actually meant to cure masturbation. The inspectorate of mental homes was displeased with Baker Brown's use of surgery in treating psychiatric patients, for which he was unqualified. A year later, the Obstetrical Society recommended his expulsion and, after a long, excited meeting, 194 fellows voted for expulsion. After Baker Brown's downfall, clitoridectomy all but disappeared in the UK, but in the USA, he still had numerous followers. According to the historian Barker-Benfield [3], clitoridectomies were performed from the 1860s until at least 1937, and removal of the clitoral foreskin was further advocated as a cure for mental illness.

Since 1872, the USA saw a new approach for the same cluster of female ailments that Baker Brown treated by clitoridectomy: *"normal" ovariotomy* [4]. During a visit to the UK, Robert Battey, a young surgeon from Rome, Georiga, in the USA was instructed in abdominal surgery by its pioneer, Howard Spencer Wells. Abdominal surgery was new and had high risks for postoperative morbidity and mortality, but also charted a prestigious path for ambitious surgeons. Battey's goal was to induce premature menopause in women, explaining their mental problems as excessive manifestations of "normal" menstrual instability and pain. Destruction of woman's orgasmic capacity was considered essential for her cure [4]. Mental health physicians fought against the ovariotomists' ambitions, but the lay public generally

Box 17.1: Quote from Spencer Wells
Fancy the reflected picture of a coterie of the Marthas of the profession on conclave, promulgating the doctrine that most of the unmanageable maladies of men were to be traced to some morbid change in their genitals, founding societies for the discussion of them and hospitals for the cure of them, one of them sitting in her consultation chair, with her little stove by her side and her irons all hot, searing every man as he passed before her; another gravely proposing to bring on the millennium by snuffing out the reproductive powers of all fools, lunatics and criminals {...}. Should we not, to our shame, see ourselves as others see us [2]?

reacted enthusiastically, with high expectations of a surgical cure for their incomprehensible ordeals. Battey's British educator, Spencer Wells, restricted his skills to patients with proven ovarian pathology, and fiercely criticized castration for mental illness. Moreover, he sketched a remarkably cynical, feminism-forecasting interpretation of the male doctors' lack of respect for female genitals (Box 17.1).

By the end of the nineteenth century, increased knowledge of the ovary's endocrine function, exacerbated by the disappointing results of the surgery, induced greater restraint in the frontrunners of female castration, but a considerable number of surgeons had already followed in Battey's footsteps. In 1906 the number of castrated American women was estimated at 150,000 [4], with some mental institutions embracing the procedure. A significant number of their surgeons were female [1]. However, Battey's ideas were not well accepted in European circles. In England, Spencer Wells was highly critical; in Germany, the procedure was introduced as Battey's and Hegar's operation, but then abandoned within a few decades; in France, the idea of "peripheral irritation" was denounced. Charcot, the Salpetrière's reputable director, was convinced that hysteria's cause was located in the brain, not peripherally.

Surgeries for hysteria are abhorrent for today's readers, but non-surgical approaches were sometimes equally incomprehensible. Maines [5] recounts classic medical theories regarding hysteria (Hippocrates, Celsus): the wandering womb, and irritation by "oppressed juices." The physician's (or midwife's) task was to massage the genitals, to bring about a "hysterical paroxysm." The orgasmic nature of this therapy had to be concealed, for fear of opening the door to masturbation. This presented a conundrum: mere chance seems to have determined that one "hysteric" woman finished up with a proficient midwife, providing her with regular orgasmic release, while another was surgically mutilated [6]. Maines's book illustrates the triumph of the cathartic method after the invention of the vibrator.

While surgical intervention was seen as a potential remedy for general psychological symptoms in women, it was also implemented for specific sexual issues. James Marion Sims, undoubtedly one of the USA's more prestigious gynecologists

[3], rose to fame for his successes related to vesico-vaginal fistula repair. However, he also dealt with the problem of *vaginismus*—involuntary contractions of the vagina in response to touch, including penetration—which unfortunately he approached surgically. He found both enthusiastic supporters and fierce opponents of his approach, a controversy illustrating profound cultural differences. In 1867, for example, the *Wiener Medizinische Wochenschrift* contrasted the surgical procedure with an alternative gentle, exercise-based approach. Moreover, French gynecologists treated vaginismus by medical massage of the introïtus and sphincter muscles [6]. In the Netherlands in 1917, prominent gynecologist Treub condemned the knife and stressed the essential psychological character of vaginismus [6]. Thus, once again, surgery was initially viewed as an appropriate treatment strategy by some doctors, but as other, often more effective, techniques became available, surgical procedures lost attraction.

17.2.2 Sexuality-Enhancing Surgery for Women

A fundamental shift in focus for genital surgeons began around 1900, with emphasis redirected from bridling unwanted sexual behavior to advancing sexual health and enjoyment. Waiss presented the case of a young married woman who was "absolutely passionless." The physician found her clitoris entirely covered by its hood, and after circumcision, the patient "became a different woman: lively, contented and happy," and sex brought her satisfaction [7]. The acceptance of this intervention in the twentieth century is poorly documented, but in the 1970s, *Playboy* and *Playgirl* advocated "*unhooding*" for easier orgasm during intercourse. This issue came to prominence well before that time, with Freud's confusing concept of "frigidity," defined as the incapacity to reach orgasm by vaginal intercourse [6]. Wondering how to explain that not all women had orgasms vaginally, he concluded that the dependency on clitoral stimulation was indicative of a fixation in an earlier, "infantile" stage. Vaginal orgasm was presumed to be "adult," so during puberty a clitoral-vaginal transfer had to take place. Soon, "frigid" became a widely used pejorative label for sexually-unsatisfied women, and vaginal orgasm was considered the acme of femininity, frantically strived for by both sexologists and lay people, women and men.

Europe witnessed a brief period of surgical frigidity experimentation, initiated by Marie Bonaparte, great-grandniece of the French emperor [6]. She was an only child whose mother died shortly after her birth and whose negligent and misogynistic father cruelly undermined her feminine self-esteem. Her "frigidity" annoyed her terribly. She had read Freud, acknowledged her profound neuroticism and went to Vienna for psychoanalysis. However, Marie never accepted Freud's analysis of frigidity. She was convinced its cause was anatomical and she published, under a pseudonym, a surprising research paper for the time. Data on 200 Parisian women demonstrated that the distance from the glans clitoris to the urethral meatus varied

from 1.25 to 3.5 cm, and those with the smaller distances were most likely to have vaginal orgasms. Consequently, Bonaparte hypothesized that surgery could fix the anatomical problem and cure frigidity. With the collaboration of a gynecologist, she developed a procedure called *Klithorikathesis*: with some subtle cuts and stitches, the distance between clitoris and introitus was reduced. Marie herself was one of the first five operated women, but overall the procedure failed to achieve its intended effect and was soon abandoned [6].

A US attempt at promoting vaginal orgasm was presented in 1983 by gynecologist Burt and psychiatrist Schramm. *Postero-lateral redirection extension vulvovaginoplasty* was supposed to cure recurrent post-coital cystitis and deep dyspareunia (pain during intercourse) [8]. Their procedure changed the vagina's angle in the pelvis so that the thrusting penis would rub the bladder floor less vigorously, while concomitantly enhancing clitoral stimulation. To maximize the advancement of clitoral orgasm, *unhooding* was added. Burt's claims of success did not cause a great stir in sexology, and eventually he was publicly denounced for performing vaginoplasties during routine episiotomy repair without patients' consent. In 1989, his career ended in bankruptcy, after seven malpractice suits.

Sexually sophisticated women nowadays are aware of the function of the G-spot and the possibility of ejaculation (squirting), but because not all women seemed able to locate and enjoy their G-spot, orgasm enhancement by *G-spot augmentation* was introduced. A bubble of collagen, injected submucosally at the position of the G-spot, was promoted for making intercourse a more effective stimulus, improving the feasibility of orgasm without clitoral stimulation. Information about this practice is non-existent in medical records, yet abundant in the lay literature. Less notable—but no less controversial—minor surgeries intended to improve female sexual self-esteem include *designer vaginoplasty* and *vaginal rejuvenation.* The American College of Obstetricians and Gynecologists explicitly disapproved of these practices.

Hymenal repair, or *revirgination*, is sometimes requested by women from cultures where evidence of virginity is of utmost importance for a bride's and family's honor. Western physicians, confronted with these practices by immigrants and refugees, condemn repair as irrational, because a perforated hymen is not infallibly indicative of non-virginity and a considerable minority of women do not bleed during first intercourse. Moreover, many physicians object ethically to upholding cultural practices that so evidently violate women's rights. A similar culturally motivated request, even more detrimental to women's health, concerns women from regions where the most drastic type of female genital mutilation (FGM) (pharaonic) is practiced. This implies critical health risks during labor (for mother and child), yet some women request episiotomy repair with restoration of their circumcised anatomy.

On the other hand, surgeons from Europe and North-America have initiated a worldwide practice of labial and clitoral repair after FGM. This practice still must be considered experimental, not yet backed by scientific evidence [9].

17.2.3 Woodruff's Perineoplasty; Feminist Critique and the Conundrum of Empirical Evidence

Genital surgery on sexological indications was never reported from countries other than European and North-American, and that is also the case for the most recent innovation. *Perineoplasty* was introduced for one specific indication, *focal vulvitis* (FV, later renamed *provoked vestibulodynia*/PVD [10]). FV was defined by specific criteria: burning coital pain in the vaginal introitus; localized redness; and small mucosal defects, extremely painful on touch by a cotton swab [11]. In three early 1980s papers, Woodruff reported on 76 operated patients, claiming near 100% success in alleviating FV symptoms.

A 2006 review (31 publications from European, North-American, and Israeli centers involving 1199 patients) summarized good results in over 80% of patients, with one notable exception [12]. This Dutch follow-up project illustrates nicely the cultural shift that feminism intended to induce in sexological practice. Vaginal orgasm was fiercely dismissed as a myth, so vaginal penetration should no longer be overrated as the *sine qua non* of sex. But the Netherlands has also illustrated that cultural differences within medicine itself may manifest themselves even within one small country: four academic sexology departments planned to cooperate in a research project on FV treatment best practices, but failed to reach agreement. Dony, from Nijmegen University, dropped out, because he was already a zealous promoter of perineoplasty [13]. Van Lunsen from Amsterdam University also stepped out for the opposite reason. As several gynecologists from his hospital had already performed perineoplasties, Van Lunsen grabbed the opportunity for a long-term evaluation. In-depth interviews with 14 patients revealed profound dissatisfaction among them. Two women were so disappointed that re-operation was ventured, without success. Modest improvement was reported by three, but only one mentioned pain-free intercourse. The project's final verdict read: PVD, including the mucosal defects, should be interpreted as inappropriate pain behavior. These women are trapped in a particular psychosomatic pain circle [14], and surgery must be condemned as a coarse, misogynistic approach, neglecting the pain's emotional meaning. Surgery serves men's interests better than women's.

Feminism is one cultural force influencing sexological knowledge in the second half of the twentieth century. Methodological developments in scientific research caused a shift from clinical, prestige-based acceptance of innovations (for instance, "normal" ovariotomy and clitoridectomy) toward academic, empirically produced evidence. Randomized controlled trials (RCTs) ousted clinical experience, but for surgical interventions RCTs are notoriously problematic. Placebo conditions will almost always show some artificiality, and blinding is often impossible. In the Netherlands, Groningen and Rotterdam Universities attempted a prospective, empirically designed study, published by Weijmar Schultz [15]. Participants started a long-term multi-modal program with randomization for perineoplasty or the placebo condition (insertion of a lidocaine-soaked tampon). The design was single blind; psychologists and physiotherapists did not know who was operated, or not. After 14 cases, an intermediary evaluation revealed negligible inter-group differences. Randomization was stopped, and in the next phase, 82% of women preferred

non-surgical treatment. Some years later, after a survey of all women treated for PVD between 2002 and 2006, Groningen's sexology department concluded that surgery must be considered only as a last resort. Even if surgery results in improvement, vulnerability for pain often persists, so patients are advised to use caution in their sex life.

A next attempt at providing empirical evidence for perineoplasty's efficacy was made by Bergeron and Binik from Montreal. Similar to the Amsterdam study, psychologists evaluated a group of surgically treated PVD patients. Twenty-four were considered successes and 14 failures, but confusingly this difference was not reflected in pre- and post-operation intercourse frequency. Satisfied *and* dissatisfied women both reported more frequent intercourse post-surgically [16].

In a subsequent prospective study, this research group compared three treatment formats: group cognitive behavioral therapy (CBT), electro-myographically controlled biofeedback, and vestibulectomy; no placebo condition was included. A 6-month evaluation revealed substantial improvement in all three groups: 39.3% (CBT) vs. 34.6% (biofeedback) vs. 68.2% (surgery). Deterioration was reported only by two surgically-treated women [17]. At 2-year follow-up, the authors admitted some ambivalence: "Although results generally continue to support the superiority of vestibulectomy over the two behavioral interventions, this is not the case for self-reported pain during intercourse, where vestibulectomy is not superior to CBT" [18]. This conclusion is, in the least, confusing: questionnaire-based success criteria maintained the conclusion of surgery's superiority, but patients' own words contradicted this. Moreover, Bergeron paid little attention to methodological flaws that evidently corrupted their empirical ambition (a detailed criticism is found in Box 17.2). Yet, her work in particular led to the widely reiterated adage that vestibulectomy is PVD's most successful approach. A 2016 example: "It is well established that surgical treatment of PVD is the most effective medical strategy to decrease the pain" [19].

Box 17.2: Weijmar Schultz and Bergeron and Binik's Methodological Limitations
Weijmar Schultz and his co-authors are candid about the difficulties of adhering to a rigorous methodology: participants were fully aware who was operated, and who had had the sham procedure. Of course, stopping the randomization also implied loss of methodological power. Bergeron and Binik, in their concluding discussion, do not pay much attention to evident methodological flaws. The lack of a placebo or waiting list condition is a major disadvantage. Randomization was disrupted by skewed drop-out numbers: participants assigned to surgery were much more inclined to withdraw from the study (7 of 29; in both other conditions only 1). Dropouts scored above average on psychological distress, which implies selection bias: the remaining surgery candidates will have a more favorable prognosis. One more detail: women assigned for CBT had significantly lower expectations, less faith in the methodology they were selected for, which could predict a less favorable prognosis. Unequal expectations cannot be excluded in uncontrolled, unblinded research projects. The authors maintained the word "randomized" in the title of their publication, which appears somewhat presumptuous.

In 1997, Nijmegen University performed a long-term follow-up study on PVD patients operated between 1991 and 1994 [20]. Dony's group was the largest such group worldwide, including 225 cases of perineoplasty. Of the 70% responding patients, 57% were completely free of complaints, but for the majority recuperation had taken a great deal of patience. Postoperative pain had been more annoying and longer lasting than expected. 16% were still unable to have intercourse, or did so only with considerable pain. In 40%, lubrication during sexual arousal was markedly reduced. As a result of these data, Nijmegen gynecologists have since abandoned surgery for vulvodynia; in the Netherlands, the chapter on Woodruff's surgical procedure has been closed. In 2002, the Montreal group also noted gynecologists' growing aversion to surgery for PVD. However, at that time, health insurance still paid for perineoplasties, but was less inclined to do so for psychological treatment [21]. This change in perspective might be a reflection of the canonization of empirical evidence above clinical experience. This cultural shift does not guarantee everlasting standards of good practice; the rise and fall of Woodruff's innovation closely resembles Baker Brown's and Battey's sad histories.

17.3 Historical and Current Perspectives on Genital Surgery in Men

17.3.1 Medical Circumcision

Marion Sims, referred to previously as the "architect of the vagina," also played a part in the introduction of non-religious circumcision of boys [22]. A former patient called on him for her 5-year-old son who suffered from leg paralysis. Sims acknowledged that this problem was beyond his expertise, so he invited a prominent orthopedic surgeon, Lewis Sayre, to his office. The boy's nurse warned the doctor against touching the boy's "willie," which had been causing him pain for some time. Upon inspection, Sayre found the glans and prepuce to be highly inflamed. This being the sole pathology, Sayre concluded that the inflammation caused a reaction in the nervous system, leading to the leg paralysis. Thus, the genital problem needed solving first. After removal of the prepuce's narrowest part, and freeing the glans from the inner prepuce surface, Sayre's expectations were fulfilled: the boy recovered, had more color in his cheeks, better appetite, and was soon able to walk properly.

Sayre's causative theory mirrors Baker Brown's defense of clitoridectomy: peripheral stimulation causes nervous malfunctioning. As with girls, with boys too, *genital irritation* often served as a euphemism for masturbation, and circumcision was supposed to inhibit self-abuse. Sayre attempted circumcision on children suffering not only from epilepsy, restlessness, and insomnia, but also from intestinal complaints. It became standard treatment for various conditions, although Sayre's disciples produced results that were less spectacular. *Preventive* removal of the prepuce became the next obvious step, with a range of diseases presumably nipped in the bud. Such preventative measures aligned with new, emerging ideals of hygiene, motivated by fear of dirt and newly discovered "germs." *Moral* hygiene contributed to the continuing popularity of the procedure in the USA. Undeniably, revulsion of masturbation motivated John Harvey Kellogg—the cereal magnate—to become a zealous apostle of *moral hygiene*. He ordained that the operation be performed

without anesthetics so boys might experience it as a punishment, regardless of whether or not they had been guilty of the sin [21].

After World War II, US obstetrical practice became rapidly medicalized and circumcision was included in the postpartum routine, paid for by health insurances. The proportion of circumcised newborns in the USA peaked in mid-1960 at about 80% [23, p. 331]. A fast rise in the 1940s and 1950s was facilitated by new technical devices (Gomco, Mogen, and Plastibell), introduced with the intention of hastening the procedure and reducing the risk of unwanted side effects. Patterns were quite different in other English-speaking countries. In the UK, circumcision was not performed on neonates, and although prevalence data are scarce, rates appear to have never exceeded 30–40%. In Australia, neonatal circumcision was common, with a steady rise to 60% in the 1960s, followed by an equally steady decline from 1970 onward. Interestingly, an ephemeral circumcision peak occurred in South Korea, beginning with the American occupation after WW II [23]. Before 1945, circumcision in Korea was rare, but the assimilation of American habits incited the lure to "modernity." Enthusiasm persisted only for a while: in 2002, over 90% of high-school boys were circumcised (though less than 10% of men older than 70); 10 years later, the percentage in the 14–16 group had fallen to 56% [24].

17.3.2 Circumcision Controversies: Debatable Benefits, Smoothed-over Disasters

Arguments regarding circumcision's *preventive effectiveness* have changed over time. The concept of reflex neurosis, mentioned previously, was eventually abandoned. In the twentieth-century USA, protection against transmission of STDs and penile and cervical cancer had been offered as reasons for circumcision, as well as a measure against lower urinary tract infections and dermatological diseases of the glans and prepuce. But routine circumcision has not been applauded by all medical authorities, and scientific debate on the pros and cons (including potential organ damage and operative risks) has been impassioned. Furthermore, ethical considerations cannot be dismissed, as summarized by one group critical of the procedure: "Physical integrity is one of the most fundamental and inalienable rights a child has. Physicians and their professional organizations have a professional duty to protect this right, irrespective of the gender of the child" [25].

In the USA, the American Academy of Pediatrics (AAP) has been viewed by the medical community as the paramount authority on circumcision. In the early 1970s, health insurance carriers asked the AAP "to determine whether or not neonatal circumcisions should be covered. They have proposed an economic question; and we, as concerned physicians, must review the procedure from its inception and offer reasonable recommendations" [26]. In 1975, an AAP task force concluded "there was no medical indication for routine circumcision of the newborn." In a surprising revision in 1989, AAP concluded there were, after all, potential medical benefits, but in 1999 in another change of thinking, a new guideline considered evidence insufficient to recommend routine newborn circumcision. A somewhat laissez faire approach concluded: "Parents should be given accurate and unbiased information and be provided the opportunity to discuss the decision" [27]. The fact that some

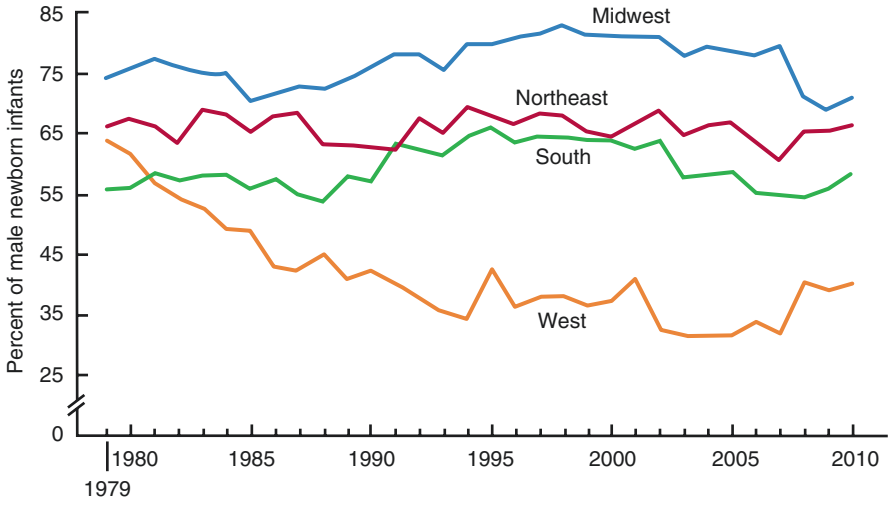


Fig. 17.1 Rates of circumcision performed on male newborn infants discharged from short-stay hospitals, by region: United States, 1979–2010. CDC/NCHS National Hospital Discharge Survey

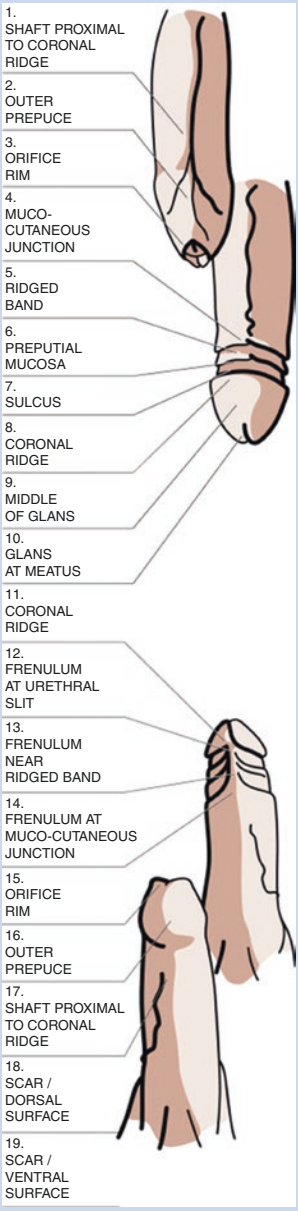
health insurance companies were reconsidering their coverage for circumcision may have been relevant to this more recent position; at least data from the National Hospital Discharge Survey illustrate impressive regional differences specifically within the USA ([28]; see Fig. 17.1). The most recent AAP iteration (2012) has once again rated the benefits of circumcision as slightly more decisive [29].

This apparent relapse in position prompted 38 European pediatricians from 11 countries to confront their USA colleagues with a charge of profound cultural bias. Reviewing the same statistics, the Europeans acknowledged only a minimal preventive effect for circumcision on urinary tract infections, a minor ailment easily treated by antibiotics [25]. Differing views on circumcision clearly expose significant cultural differences between America and Europe, a clash that has been played out in other arenas. For example, the African campaign for *voluntary medical circumcision* (VMC) for adolescents and adults—largely promoted by the American contingent via the development of two new devices intended for use in adolescents—as a preventive strategy for HIV transmission has generated substantial controversy. Evidence for the effectiveness of circumcision to reduce STD transmission has been questioned, especially concerning male-to-female transmission. Newly circumcised men were informed of the importance of condom use, but condom use was widely rejected by men in Africa and therefore the advice was often neglected. Anthropologists have been critical of outsiders' ignorance of cultural assumptions that "being intact" is sometimes critically important to the tribal identity [30].

The AAP appears to pay more attention to potential benefits than to negative side effects on sexual functions. Removing the foreskin could imply loss of erotically sensitive skin and mucous membrane, with an abundance of nerve endings and sensory corpuscles. In Victorian times, diminished sensitivity was intended to counteract masturbation [22]; today the concern is the contrary: does circumcision diminish sexual enjoyment? An often quoted survey on penile fine touch charted differences in

monofilament pressure thresholds for 19 precisely defined positions ([31], Box 17.3). Circumcision was found to ablate the most sensitive parts of the penis: the transitional region from the external to the internal prepuce. The glans also loses some sensitivity.

Box 17.3: Elements of Circumcision



Along this line of thinking, for decades it was assumed that circumcised men had a lower risk for *premature ejaculation (PE)*, and the operation was sometimes propagated as treatment for this dysfunction, but research outcomes have been ambiguous. The International Society of Sexual Medicine (ISSM) and American and European Urological Societies no longer indicate circumcision for PE. However, in past decades, enthusiasm had surged for curbing penile sensitivity: in Iran, Robati reported on 47 circumcised men complaining of PE. He hypothesized the non-keratinized sleeve of prepuce skin caused PE, so he reoperated to remove these remnants. His claim of spectacular results is in urgent need of replication [32]. A recent overview of treatments for PE identifies several Asian studies claiming significant results for selective dorsal neurectomy (SDN), either as a last resort for those who have not benefited from other treatments or for those adamantly wanting a permanent solution [32]. Consequently, SDN was recently included in the Chinese Andrology Guidelines [33]. A South-Korean group also tested SDN, as well as glandular augmentation (2 cc of hyaluronic acid injected into the glans) to treat premature ejaculation by diminishing penile sensitivity [34].

Circumcision's effect on sexual functioning is still a topic of discussion. In 1982, Money presented long-term follow-up data on medically indicated circumcision in five adult men [35]. One man's surgery was too aggressive/injurious, leading to serious pain and dissatisfaction. None had PE complaints before circumcision, but all mention diminished sensitivity and longer latencies to ejaculation. That is, generally circumcision had not changed sexual functioning much. The South-Korean circumcision data mentioned previously included 593 sexually experienced men [23], 80% of whom had not noticed postoperative changes in sexual function. If change was mentioned, more often it was about deterioration than improvement. The Danish Health and Morbidity Study, a large-scale long-term population-based interview survey on public health matters, revealed that although circumcision status made no difference in the prevalence of either erectile dysfunction or premature ejaculation, circumcised respondents reported orgasm difficulties more frequently, and their female partners mentioned "incomplete sexual needs fulfillment" more often. Partners also had higher numbers on dyspareunia [36].

A 2000 British survey on medical circumcision reported a prevalence of 6.5% in the mid-1980s. The authors concluded that *phimosis,* a condition where the foreskin cannot be retracted, was the most frequent indication, and they emphasized that this condition was over-diagnosed [37]. The tendency to label all tight foreskins as phimosis is a remnant from the nineteenth century fallacy of *congenital phimosis* [38]. At birth, foreskin tightness is as common as open fontanels in the skull; the boy's own manipulations typically eventually stretch and loosen the prepuce so it can be retracted. Parental hygienic instruction is also beneficial; if a boy's prepuce is still tight at primary school age, he may be encouraged to overcome his inhibition, to develop a better relationship with his private parts and their sensitivities [39].

Surgical sequelae of circumcision have on occasion been dramatic. A classic botched circumcision case was that of Bruce Reimer. At the age of 8 months, he and

his twin brother Brian were diagnosed with phimosis, and so both were scheduled for circumcision. When Bruce's circumcision burnt most of his penis during cauterization, Brian's was cancelled, and eventually, his tightness disappeared spontaneously. After his mutilation Bruce came into the care of psychologist John Money, an expert on gender issues, who advised the parents to solve Bruce's predicament by changing his sex of rearing. He was raised as "Brenda" and for some time Money tracked the progress of both twins' gender assimilation and identity. In numerous research articles he pronounced this case a sound illustration of his hypothesis that by and large nurture (sex of rearing) triumphs over nature (biological sex) in establishing gender identity and role. Bruce, however, never fully identified with his female gender role, and by his 15th year had actually resumed a male gender identity. For whatever reason, his life was not a happy one, and neither was his brother's, as both ended their lives through suicide [40].

Botched circumcisions are rarely reported in American medical publications, but in lay and juridical media, a grim reality is implicated. An activist organization, Attorneys for the Rights of the Child, documents court settlements and financial compensations for botched circumcisions on their website. Fifty-four documented cases are reported, from 1952 to 2015, 4 of which concerned religious circumcision by a Jewish ritual circumciser (*mohel*). The highest compensation was $22.8 M, with the sum total amounting to over $84 M. In two cases sex changes like Reimer's were performed. Attorneys for the rights of children have emphasized that a substantial number of court cases end in sealed settlements, so the true incidence of such cases may be substantially larger than documentation suggests.

17.3.3 NOCIRC, Uncircumcising, Foreskin Restoration

Some circumcised men deeply regret the loss of their foreskins, voiced in, for example, Auslander's *Foreskin's lament: a memoir* [41]. Today's nationwide abolition movement, the "intactivists," was inspired directly from the operating room: a young nurse, Marilyn Milos, witnessed a circumcision and, as she stated, "heard screams that will haunt her to her grave." She gathered a group of healthcare professionals in San Francisco who in 1986 founded the National Organization of Circumcision Information Resource Centers (NOCIRC). Cooperation was sought with UNCIRC, a lay group promoting foreskin restoration. Surgical *un*circumcising has a long history, beginning with the second-century Greek philosopher and physician Celsus. In his time, the persecution of Jews by Roman oppressors motivated "uncircumcising," and more recently Jewish men who were trying to hide their religion during WW II resorted to it once again. To avoid free skin transplants, scrotal skin was used: skin from the shaft was cut at the base and sculpted into an inner and outer layer of prepuce, after which the denuded corpus was buried in the scrotum. After several months of circulation adaptation, the scrotal skin was used to cover the shaft [42]. Today's circumcision regretters have learned that foreskin stretching can be successful in about the same length of time as surgery, so surgery has been abandoned, as described in Bigelow's 1992 book *The Joy of Uncircumcising* [43].

Although empirical research on stretching is almost absent, social media provide a rich treasure trove for fellow sufferers, with photographic and video testimonies of successful processes.[1]

Social scientists and feminists have added to the debate. Regarding the latter, a woman-initiated NOCIRC, and women's emancipatory ambitions have influenced the discussion, as illustrated by the title *Foreskin is a feminist issue* [44]. Feminism's focus on embodiment can shed a new light on male bodily integrity, as it has for female genital mutilation.

17.3.4 Law Courts and Political Advocacy

American physicians performing infant circumcision have generally dismissed the voices of "*intactivists"* and "*uncircumcisers*," as well as some of the procedure's inextricable ethical dilemmas. The *Human Rights/Rights of the Child* arguments are wholly subservient to parental rights [23, p. 331]. Lawyers too sometimes enter the fray when parental fights over children's circumcision end up in court. Wikipedia's Lemma Circumcision and the Law reports on six cases between 2001 and 2007, including a recent notorious case concerning 4-year-old Chase. His parents, not living together, had regulated parental authority in a contract. When the father wanted the boy circumcised, the mother objected and the parents went to court, which decided in favor of the father. The mother fled with her child to a violence shelter, but was arrested and forced to sign a consent form. Through social media, a large counterforce of intactivists assembled in front of the hospital where the circumcision was expected to occur, and nurses were appealed to refuse assisting at the surgery. The turmoil has since subsided, but the general public never came to know whether or not the boy was circumcised.

Further initiatives against circumcision have occurred. For example, in 2011 intactivists in San Francisco garnered 12,000 signatures to support a proposed bill to Congress to prevent circumcision, the Male Genital Mutilation Bill; but such laws are generally considered unconstitutional in the USA, as they violate freedom of religious expression.

17.3.5 Scientific Vs Emotional Debate

Intactivist scientists held their first International Symposium on Genital Mutilation in 1989 in Anaheim, California, where a final declaration ended with a profoundly ethical statement: "Physicians who practice routine circumcision are violating the first maxim of medical practice, Primum Non Nocere (First, Do No Harm), and anyone practicing genital mutilation is violating Article V of the United Nations Universal Declaration of Human Rights: No one shall be subjected to torture or to cruel, inhuman or degrading treatment …" Since that initial meeting, 14 symposia

[1] A most convincing example: https://www.youtube.com/watch?v=I9UrxAKeyV4.

followed, with various emphases. The fifth symposium, for example, scrutinized problems in medical publications [22, p. 379], with the contention that peer review did not adequately ensure against a pro-circumcision bias.

Pro and con voices regarding circumcision have at times been impassioned. At the 1996 AAP meeting, for example, Gellis contended "It is an incontestable fact at this point that there are more deaths each year from complications of circumcision than from cancer of the penis" (the latter being one of the arguments used to justify circumcision). He later noted that some fatalities resulting from circumcision are registered as death due to sepsis, obscuring the fact that circumcision was the instigating cause. In 1997, the pro-circumcision spokesman, Wiswell, countered: "Over the past 45 years, four deaths of neonates have been attributed to circumcision. During the same period, more than 11,000 uncircumcised men died from penile cancer." Fleiss, another pediatrician, fact checked Wiswell's sources and found empirical data supporting this contention to be scarce, most being drawn from opinion papers and textbook chapters [23]. Around the same time, Frisch published Danish data concluding that penile carcinoma numbers were declining in that country, where circumcision had always been rare [45].

Some 17 years later, Frisch described an example of the challenges encountered in publishing data that were critical of circumcision, in this case related to the finding that circumcised men (and their partners) were more vulnerable for some sex problems [35]. In response to a critical *Letter to the Editor*, he divulged the tedious obstructions he encountered during the review process as follows: "I would like to thank the IJE editors for withstanding the pressure from one particularly discourteous and bullying reviewer who went to extremes to prevent our study from being published. After the paper's online publication, […] one colleague informed me that the angry reviewer was the above Letter to the editor's first author [i.e., Brian Morris—an Australian molecular biologist]. In an email, Morris had called people on his mailing list to arms against our study, openly admitting that he was the reviewer and that he had tried to get the paper rejected. To inspire his followers, Morris had attached his two exceedingly long and aggressive reviews of our paper (12,858 words and 5291 words, respectively), calling for critical letters in abundance to the IJE editors. Breaking unwritten confidentiality and courtesy rules of the peer-review process, Morris distributed his slandering criticism of our study to people working for the same cause [46]."

In both his publications, in the *Conflicts of Interests* section, Frisch identified himself as an opponent of preventive circumcision, and he reprimands Morris for omitting his *Conflict of Interest* stance as an activist in support of circumcision. Morris, for example, edits the pro-circumcision website Circinfo, in cooperation with two British fellows, Quaintance and Waskett, who share similar views but lack academic credentials. Morris's boldest aspiration was an appeal to the Australian government for a law for compulsory circumcision of all boys, likening those who oppose circumcision to those who are anti-vaccination. However, in this respect, Morris clashed head-on with the Australian Academy of Pediatric Surgeons. Circinfo's information is tirelessly rebutted by Intactwiki, an intactivist website that suggests some advocates in this group may be circumfetishists. Fetishist should be understood in its literal, psychiatric meaning. In Box 17.4, the interested reader can find more information on this unsavory aspect.

Box 17.4: When Paraphilia Impersonates Medical Practice

Circinfo's circumfetishist characteristics were exposed already in the 1998 Proceedings of the fifth Circumcision Symposium by international lawyer Price [23]: "It is likely also that mutilating the genitals of others has a deep sexual motive. […] For those who can stomach it, the comments and behaviors of proponents of circumcision would make a fruitful area of psychological study. […] It would seem wholly plausible that inflicting circumcision on a boy provides some circumcisers and onlookers with a sexual thrill. Groups such as the Acorn Society, the Gilgal Society, and the Cutting Club openly admit to a morbid fascination with circumcision to the point of sadomasochistic fetish. These groups advertise that doctors are among their members. There are those on the Internet who discuss the erotic stimulation they experience by watching other males being circumcised, swap fiction and about it, and trade in videotapes of actual circumcisions. Furthermore, there are anecdotal accounts of doctors becoming sexually aroused when circumcising boys".

Since 2012 Circinfo is in trouble, because Quaintance was accused of, and convicted for, the possession of child pornography and, some years later, of child sexual molestation. His name is erased from Circinfo publications, and Gilgal and Acorn Society websites have disappeared. However, some of their quotes are still to be found in Intactwiki:

- *CircumciseR:* "Some of us do get sexual gratification from the finished product, but also the procedure itself. The act of becoming a man is just as important as the head he shows."
- a fragment of circumcision porn in which the narrator, in an almost playful, boys scout-like atmosphere, observes five teenage boys being circumcised. A lot of wine is consumed as anesthetic, and one boy is stimulated to satisfy himself during the waiting time, so that the doctor can show him his spermatozoa under the microscope.
- a picture of a man masturbating above a restrainer, designed especially for circumcisions of newborns: a kind of Styrofoam bathtub with a human form and four pairs of Velcro strips for immobilization.
- *Icut4skins* boasts his collection of more than 400 foreskins;
- *Rodjarrell*: complains that his own circumcision has been not drastic enough to his taste, so he wants an overhaul, preferably by a female surgeon.
- a mail from a doctor who circumcised himself, and a sultry story in which a woman circumcises her husband, which action excites her immensely. Reality or masturbation fantasy? Coming from a man or a woman?

17.3.6 Sexual Dysfunction Repair

Impotence, better known nowadays as erectile dysfunction (ED), is the world's most predominant sexual dysfunction, and as early as the thirteenth-century BCE, clay tablets providing recipes for erectile problems have been found. Freud postulated psychodynamic processes in impotent men, and ever since Masters and Johnson first introduced sex therapy in the 1960s, careful diagnosis of somatic, intrapsychic, and relational aspects have been the pillars of *good clinical care.* Sexology's bio-psycho-social basis to understanding and treating sexual problems has been widely endorsed, but a worldwide parallel search for symptomatic approaches has also gained momentum. Vacuum devices that produce penile engorgement had the advantage of minimal adverse effects; intracavernous injection of vasoactive medications (ICI) were effective but sometimes resulted in priapism, a urological surgical emergency; implantation of erection devices inevitably destroys the patient's residual erectile capacity, limited as it may be. However, since the introduction of the more advanced three-piece inflatable penile prosthesis (IPP), surgical implantation has become a worldwide standard as a last resort.

Cultural differences are apparent in the level of caution with which sexologists and urologists try to avoid possible harm and disappointment. In Amsterdam, where 100 years ago a gynecologist warned his colleagues for unrealistic expectations (in doctors and patients) of surgery for hysteria and unexplained *female ailments*, couples complaining of erectile failure now undergo a thorough diagnosis, including a Waking Erectile Assessment (WEA). When this assessment shows a 12 mm gain in penile circumference during stimulation, the candidate is firmly discouraged from moving forward toward IPP [47]. In other words, IPP should be considered only as a last resort. With good reason: IPP recipients are a notoriously difficult group with regard to (dis)satisfaction. Tiefer, researching long-term results of IPP, was surprised by recipients' lack of cooperation and sometimes outright hostility. Some patients deliberately hindered their partner's participation, yet in 15–19% of partnerships, the prosthesis had caused some relationship deterioration [48]. Meuleman reported, first in 1991, and later in 2001, that IPP surgery did not generally improve sexual or relationship satisfaction. In fact, 1 in 4 men had never even used the device, a surprising discovery because after the disappointing outcomes of 1991, effort focused on helping men/couples set realistic expectations. The 2001 article closes with a passionate plea to extend counseling to the *post*operative period [48]. This stance was reaffirmed at a 2019 conference attended by equal numbers of urologists and psychologists.

In the USA, avoiding postoperative dissatisfaction with its possible legal consequences motivated the 2013 publication of pitfalls for IPP surgeons. This accredited Continuing Medical Education included a mnemonic for warning signals related to patient–doctor disagreement (see Box 17.5). Implant candidate's attitude toward other treatments is relevant: those refusing to try non-invasive options (PDE5-inhibitors, ICI, or vacuum device) were more at risk for dissatisfaction. As for malpractice suits, IPP surgeons are in the same high-risk group as plastic surgeons.

Box 17.5: CURSED Patient [55]
*C*ompulsive/obsessive character traits;
*U*nrealistic expectations;
*R*evision surgery experienced or strived after;
*S*urgeon shopping tendencies;
*E*ntitled (mainly strong narcissistic character traits);
*D*enial of prior sexual problems and/or current disease status;
*P*sychiatric disorders in general.

17.3.7 Male Genital Surgery: Repair and Improved Self Esteem

As previously noted, cosmetic surgeons have catered to the wishes of women wanting to enhance stereotypical feminine characteristics, both anatomically and relevant to sexual functioning. Surgical interventions have also catered to male stereotypes, for example, ensuring endurance (i.e., delaying ejaculation) in order to satisfy female partners, a target for surgical penile nerve cutting in Asian countries to treat premature ejaculation. A more widespread masculinity concern, however, is that of penis size.

Only a minority of applicants for penile enlargement meet the accepted criteria for a diagnosis of a micro-penis (flaccid length <7.5 cm). Most enlargement seekers have an unrealistic genital self image, and some fulfill the criteria for body dysmorphic disorder. A multidisciplinary group in Europe reported on 60 enlargement applicants, of which 44 were reassured by information of their unrealistic self-appraisal and thus ended up foregoing surgery [49]. Individuals, most often in East Asia, sometimes take it upon themselves to provide a home remedy for penile enlargement, including penile self-injection with petroleum jelly or paraffin, with potential side effects of paraffinoma and/or skin necrosis [50]. The cost of surgical enhancement is typically not borne by health insurance providers; nevertheless, many men find willing surgeons who will enlarge penis size through synthetic fillers, autologous fat, vein strips, or fibroblasts, taken from scrotal tissue. A review of studies on surgical enlargement for men with normal penile dimensions found insufficient methodology in most studies [51].

True micro-penis problems are sometimes manifestations of intersex conditions, where individuals, for any number of prenatal anomalies, may have been born with any of several variations in sexual anatomy that may include both male and female characteristics. Such individuals may have an excessively large clitoris or, alternatively, a very small penis and therefore, may be candidates for surgical intervention. However, in today's "emancipated" environment, such routines are no longer self-evident. This attitude has been reinforced by clinical experience which has led to the abolishment of feminizing surgery for penis-less boys (the Reimer case) and a tendency to refrain from "normalizing, feminizing" surgery until the age of consent. From a feminist perspective, clitoral reduction may imply disrespect for woman's

sexual expression and enjoyment. Furthermore, support groups have emerged to help normalize intersex individuals. For example, the patient advocacy group, the North American Hermaphrodites with Attitude, which associates with GLBTI political activism, considers the intersexuality, in which individuals reject the need to choose between male and female, to be an acceptable gender identity. Such activist positions are likely to catch on at a more global level.

Micro-penis patients are candidates for *phalloplasty*, surgical construction or reshaping of the penis. A review on quality of life indicators following micro-penis treatment (hormonal and surgical) noted etiologies ranging from disorders of sexual development, bladder extrophy, amputation for carcinoma, and traumatic and iatrogenic amputations, including botched circumcisions [52]. However, most phalloplasties are requested by female-to-male transsexuals seeking to replace female genitalia with male-like genital structures. Such procedures are now available worldwide and require construction of a neo-phallus which involves implanting an Inflatable Penile Prosthesis (IPP) to simulate erectile function. Interestingly, a number of male-to-female transsexuals wishing to return to the male gender regret their decision to lose their penis. In such instances, reverse surgery involves removal of the neovagina with scrotoplasty, phallo- and urethroplasty and, in some instances, penile prosthesis implantation. Most patients who have undergone this reversal have been satisfied with the appearance and function of their new genitals; however, as with sexual reassignment surgery, quality of relationship with the partner counts among the strongest predictors of postsurgical satisfaction [53].

The most dramatic genital-anatomic intervention is the *penis transplant*, motivated by a variety of experiences. For example, in China, a 44-year-old man, having lost his penis in an accident, received the penis of a 22-year-old brain-dead donor. Although the intervention was technically successful, the recipient and his wife requested removal 14 days later for psychological reasons. In South Africa, where ritual circumcision results in 250 penile amputations annually, a 21-year-old amputee received a penile transplant in 2014 that was characterized by a rapid recovery and good sexual functioning, resulting in his partner's pregnancy within a year. A second success followed shortly thereafter. In the USA, war veterans, having lost their genitals, have provided an impetus for penis transplants. With the aid of immune tolerance medication, by 2018 two men had successfully received donor penises [54]. In response to the need for donor penises, plastic surgeon Djordjevic has promoted the idea of using penises of male-to-female transsexuals as donor organs for those needing implants.

17.4 Synthesis: The Role of Culture in Acceptability of Genital Surgery

This overview of surgical interventions on female and male genitals has been limited to *medical* practices (curation and prevention) and does not consider those done for religious or traditional reasons (e.g., clitoridectomy and circumcision). For medically based genital surgery, scientific evidence to justify the procedure has often

been weak or absent, reinforcing the idea that cultural dispositions were often the driving forces for such practices. Furthermore, these cultural dispositions have shown significant changes over time.

In surgery's mid-nineteenth century pioneer years, prominent physicians in the UK and USA promulgated clitoridectomy, ovariotomy, and male circumcision for a variety of indications, including mental instability. Strong opposition from mental health physicians in the UK resulted in abolishment of clitoridectomy, but in the USA the practice persisted for several decades. "Normal ovariotomy," an American innovation, was fiercely criticized by prominent physicians in the UK and France, indicating the different cultural medical milieus within Western medicine. Medical male circumcision, first as a cure for neurological and mental health indications and later as a preventive measure for such symptoms, is among the more persistent forms of medically justified genital surgery. Circumcision eventually developed into a neonatal routine embraced predominantly in English-speaking nations, and most extensively in the USA, suggesting a US cultural preference for surgical procedures for managing some medical issues. Hysterectomy prevalence also illustrates this point: in the New York Times, in 1997, feminist researcher Nathalie Angier informed the American lay public: "By the age of 60, 1 in 3 American women will have had their uteri removed. In Italy, by comparison, the figure is 1 in 6 women, while in France, it is only 1 in 18."

Around 1900 the goals of genital surgery shifted: instead of attempting to curb sexual indulgence and masturbation, it was promoted for sexual health, self-confidence, and enjoyment, particularly in women. These endeavors championed temporally-bound ideals of healthy sexuality, with vaginal orgasm (the legacy of Freud) at its center. While most of these surgeries have long since faded, clitoral unhooding to facilitate orgasmic capacity is yet practiced today, though data are generally scarce. Discussion of cosmetic surgery on female genitalia is prolific within current social media, but because the procedure has received little legitimacy within medical circles, its prevalence is unknown.

Gender-related ideals and expectations are often culturally prescribed and reinforced. For example, the fixation on penis size as critical to female pleasure persists and is manifest in requests for penile enlargement in men whose penis sizes fall within the normal range. Such procedures cater to men's need for higher self-esteem by fulfilling specific, often exaggerated, ideals of masculinity. As with other marginal practices, data on the prevalence of such surgeries (or on home penile enlarging efforts by self-injection of synthetic substances) are unavailable.

Changes in gender expectations over time also affect medical practice. A shift in cultural standards, beginning in Western societies, was instigated by the women's equal rights movement during the first half of the twentieth century that included voting rights, paid labor, and parental/property rights. This early sexual revolution, followed by a second wave in the 1960s, recognized the nature and validity of sexual interest, desire, and pleasure of women. Feminist initiatives inspired sexologists to embrace the true bio-psycho-social foundation of their profession. Surgical innovations often focused on sexual pleasure: G-spot augmentation promised women higher self-esteem by better adjustment to the heterosexual ideal of female sexual

functioning during penile-vaginal intercourse. Perineoplasty focused on relief from dyspareunia, which was arduously debated in the Netherlands. The eventual downfall of perineoplasty in the late twentieth century, due to a lack of strong scientific support, mirrors more or less the nineteenth-century abolition of surgery for hysteria.

Today, although sexology and its professional organizations are represented worldwide across all continents, strong cultural differences persist, revealing large populations that have not benefitted from enlightened thinking regarding gender equality. Religious orthodoxy often forms the foundation for rigid scripts regarding female and male sexual behaviors. The cultural emphasis on virginity in many regions of the world is an example that has serious consequences for women, leading to irrational and exaggerated expectations of bleeding at first intercourse, sometimes instigating hymenal repair for women who fear being branded "non-virginal" in the bridal night. Surgeons educated and/or practicing in gender equitable societies sometimes receive requests for hymen repair/revirgination, which brings them into conflict with modern ethical standards. Similar dilemmas are reported around traditionally circumcised women who request postpartum refibularization: surgical repair of their clitoridectomized anatomy.

Even when religious orthodoxy does not play a role in specific "genital" expectations for men or women, cultural differences in the acceptability of specific genital surgical procedures exist. For example, the ISSM has rejected surgical treatment for premature ejaculation, yet Asian countries have promoted selective dorsal neurectomy (SDN) as a last resort for patients who have unsuccessfully attempted other treatments, or who adamantly request a permanent solution. SDN is perceived to have generated sufficiently positive outcomes through empirical study; it was incorporated into the guidelines of the Chinese Andrological Association.

Finally, within Western medicine, essentially founded on principles of observation and measurement, discordance persists regarding the value of male circumcision. European medical professionals condemn the procedure, pointing out its high risk/low benefits, whereas American medical professionals—while not necessarily endorsing circumcision—tend to justify the procedure for sexual health and parental rights reasons. A recent confrontation of opposing cultures is seen in the American campaign for HIV prevention, promoting medical circumcision in Africa. Non-US western epidemiologists criticize this campaign for exaggerated expectations of efficacy, and anthropologists have stressed the counter pressure that is to be expected from populations in which being uncircumcised is one of the roots of their cultural identity.

17.5 Conclusion

A historical analysis reveals how medical practice is often rooted in the values and culture of the time, and is sometimes related to the prestige of specific individuals. As these values undergo change, practices have changed along with them. Although

today's emphasis is on evidence-based practice, cultural acceptance and tradition continue to play strong roles as to what is acceptable and what is not, seen, for example, in the Asian vs. Western endorsements of penile dorsal nerve cutting for premature ejaculation, or the striking differences in attitudes regarding male circumcision in the US vs. Western Europe.

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Pornography Use: What Do Cross-Cultural Patterns Tell Us?

18

David L. Rowland and Dudbeth Uribe

18.1 Introduction

Pornography—the representation and depiction of sexuality and sexual acts for public consumption—has been richly portrayed in ancient Greek and Roman civilizations [1]. Undoubtedly, the tradition long pre-dated these civilizations: depictions of erect penises date back to the Stone Age era and the bas-reliefs of Egyptian culture [2], as much symbols of fertility as male prowess. Manuals regarding sex and love-making have permeated the ages, from Ovid's *The Art of Love* and Plato's *Symposium*, to the infamous *Kama Sutra* [3, 4]. In contrast to the public display of sexuality, the desire for privacy regarding the expression of sexual behavior appears to be primarily a human characteristic, although whether such need was associated with more recent Western civilizations is not known. Most other species advertise their sexuality as a means of revealing fertility and asserting dominance within species and social groups. Secrecy among non-humans surrounding sexual behavior appears mainly to be a mechanism designed to ensure safety rather than an expression of modesty.

What has changed over the centuries has been the production and potential distribution of (and thus access to) pornography. Although historical documentation appears to be scant, one can, for example, imagine the potential impact of media transitions on the production (and proliferation) of pornography, including the invention of the printing press, still photography, cinema, and eventually home video and CD players—these latter developments removing much of the public stigma associated with pornography use, as consumption became possible in the privacy of the home.

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Furthermore, although changes in the production, depiction, and format of pornography had long affected the availability of pornography, its *distribution* has also played an important role. Many societies have attempted to regulate the distribution of pornographic materials on moral grounds by banning depictions of nudity, sex acts in general, specific sex acts, specific participants (e.g., children), and so on, and by making possession of such materials either by individuals or production firms a criminal offense.

Now, of course, the situation is radically changed; in the age of the internet, the major barriers to pornography use are no longer relevant. Specifically, pornography is mass produced, can be viewed in private (and secretly), and can be accessed by nearly anyone living anywhere who has access to the internet—essentially obviating the once-limiting role of societal restriction. In one recent study involving Australian and Danish male participants, the average frequency of porn viewing was 3–4x/week, with sessions typically lasting 15–30 min. The first use of porn averaged around 13 years, with most males becoming regular users by 16–17 [5].

18.2 Effects of Pornography

Social restriction on access to pornography is predicated on the assumption that pornography imparts negative effects to individuals and thus to society at large. Traditionally, these effects have been framed as moral or religious issues—ones involving temptation, sin, depravity, and consequences of self-indulgence, promiscuity, infidelity, and threat to the family unit. More recently, these negative consequences have found secular parallels, often ones involving psychological health and social welfare. Such purported detrimental consequences include, but are not limited to:

1. Effects on the individual's sexual response, for example men experiencing erectile dysfunction with their partner because their sexual experiences do not mirror the highly arousing situations portrayed in the pornographic materials [6].
2. Potential addiction to pornography in the sense that stronger, more potent (and often more deviant) pornography is required to achieve arousal, as the individual becomes habituated to lower levels of stimulation [7].
3. Effects on relationships, where sex with one's partner may pale in comparison with the sex acts and models depicted visually (often on screen)—partners may be less willing to engage in those specific sex acts, and/or may not be as sexually provocative as the models.
4. Focus on the physical characteristics of sexuality, including objectification of possible sex partners only as vessels of pleasure, at the expense of encouraging a more holistic view of sex that involves emotional, attachment, and cognitive elements. Such issues become particularly relevant with respect to sexual violence [8, 9].
5. Encouragement of higher risk sexual activities, including specific sexual behaviors such as anal sex, kink (e.g., sado-masochism), group sex, and so on, as well

as riskier sexual overtures based on assumptions that (most often) women in pornography are representative of all women's promiscuity/willingness to engage in sex [10, 11].

In many situations, men *have* been found to endorse one or more of the above negative effects, particularly, for example, if they have just viewed a pornographic clip [5]. They might, for example, express interest in a greater variety of behaviors with their partner, see their partner as less adequate, and indicate the desire for activities that might induce greater arousal. However, the more salient questions revolve around the longer-term effects of pornography on sexual response and relationships, and these are more difficult to discern.

18.3 Empirical Findings Regarding the Mixed Effects of Pornography

Much research has been conducted on the ill-effects of pornography on viewers,[1] and although it is difficult to reach uniform or singular conclusions, several possibilities exist [12]. The first is that pornography use may have negative effects on sexual functioning and relationships in some individuals, but it is by no means inevitable. The second is that pornography use might be viewed as a "risk" factor for negative effects rather than a cause: that is, many individuals who use pornography seem largely unaffected by it. And third, a variety of possible outcomes might result from pornography use, some negative and some positive, depending on complex factors involving usage frequency, type of pornography, personality traits, relationship factors, and cultural expectations.

18.3.1 Pleasure and Instruction/Education

Pornography is often used as stimulus materials for masturbation by both men and women. For example, young Croatian women positively associated pornography with masturbation and self-pleasure [13]. Among men from three European countries, one analysis reported that 70% regularly used pornography during masturbation [14]. Research carried out in southern Africa suggests that girls view pornography as a means for both education and pleasure [15], a sentiment somewhat echoed by Black and Hispanic youth in the USA as well as gender nonconforming Canadians who watched pornography for instructional purposes, entertainment, and sexual stimulation [16, 17]. Interestingly, most men perceive more positive effects from pornography use than negative effects, although the perception of positive effects does not guarantee positive outcomes [5, 17, 18].

[1] We restrict our discussion to the effects of pornography on viewers and not on those who participate in the industry. Although data are scant, pornography may encourage negative social outcomes such as sex trafficking, racial and sexual stereotyping, and sexually transmitted diseases.

18.3.2 Risky Sexual Behaviors

Under some circumstances, pornography can have clear negative consequences. For example, the Black and Hispanic youth in the above study often copied the behaviors they saw in pornographic material, sometimes to the detriment of their dating relationships [16]. Furthermore, to the extent that youth might mimic behaviors depicted in pornography, content involving sexual violence may increase aggressive tendencies, particularly toward women, with some research showing an overall positive association between pornography use and attitudes supporting violence against women [19]. However, in a separate analysis, these authors readily acknowledged that cultural and contextual differences may play a key role regarding such associations [8]. In Kenya, among adolescent and minor males and females, for example, pornographic video shows combined with alcohol at local "brew dens" increased risky sexual outcomes, including forced sex, gang rape, multiple partners, and particular female vulnerability due to unequal power dynamics [20]. In such contexts, pornographic material may well establish unrealistic assumptions and expectations about the nature of sexual interactions with partners and about what partners (particularly women) are apt to enjoy. In contrast, a recent study of Croatian adolescents found no association between the frequency of pornography use and risky sexual behaviors defined in terms of condom use and multiple partners [21].

18.3.3 Sexual Satisfaction and Performance

Given that pornography may establish unrealistic norms for sexual performance and behavior in the eyes of some viewers, it has also been suggested that the male and female models acting in pornography set up unrealistic expectations regarding body physique and sexual prowess. Among Dutch men, frequent exposure to pornography increased body dissatisfaction, particularly with respect to abdominal appearance, less so to penis size [22], although this relationship was not observed in women from the same study or a separate sample of Scandinavian men [23]. In fact, in the latter study, the authors concluded that "pornography may expand the sexual scripts of both men and women, and may have a positive, although modest, influence on sexual self-esteem of young male adults." Regarding the use of pornography and sexual performance in men, a recent overview reported mixed findings, with some tendency toward decreased sexual satisfaction among frequent users, but no clear effects on erectile or ejaculatory function [24, 25].

18.3.4 Relationship Issues

Although numerous studies initially suggested negative associations between pornography use and relationship satisfaction [26], more carefully controlled analyses provide either minimal or no support for such associations. For example,

pornography use is unassociated, or becomes unassociated, with relational happiness once masturbation is controlled, as masturbation tends to be negatively related to relational happiness in men and women [27], a finding that was, in part, confirmed by an independent study on the topic [28]. In addition, an attempted replication failed to support the idea that men, but not women, in committed relationships found their partners less attractive when exposed to erotica, thus calling the original findings into question [29]. Indeed, one study suggests that sexual satisfaction with the partner may be bolstered by promoting sexual variety [28], and other research involving both men and women indicates that participants most often perceived no negative effects from pornography on their relationships and identified positive outcomes that included improved communication as well as increased sexual comfort and experimentation. Less frequently, negative outcomes were identified, such as unrealistic expectations, decreased desire, and increased insecurity [30].

All in all, then, pornography use has the potential to exert both positive and negative consequences, with no broad generalized conclusion possible. Clearly, the way in which the content is presented, the content itself (e.g., violent or not), and the perceived realism of the content (is it perceived more as fantasy than as a realistic depiction of sexual interactions?) are all likely to affect outcomes. In addition, the cultural context and expectations surrounding the viewing of pornography are relevant. In a social system that views pornography as sinful and forbids masturbation, the use of pornography which entices the individual to masturbate may cause great distress and guilt and lead to rejection of sexuality as a pleasurable, intimate activity. On the other hand, in a more open social system that tolerates sexual variation, couples may find pornography piques their interest, suggests new ways toward mutually enhanced sexual satisfaction, and improves sexual communication.

18.4 Aims of this Analysis

Here we take a cross-cultural look at pornography use, with the goal of describing patterns and trends across various regions of the world. Use patterns included overall frequency of use, usage per capita when available, time spent visiting websites, and type of content and actors, with some information further parsed by gender and age. We also explored relationships between pornography use and several global/sociocultural variables of interest. These included two World Health Organization (WHO) indices, one on Human Development (Human Development Index: HDI) and the other on gender inequality (Gender Inequality Index (GII)) [31]. We also generated a Trans/Homophobia Index (THI) and a measure of Internet Use. We selected these indices as they provide a number of proxy measures for general openness/tolerance to sexuality and sexual variation, the assumption being that greater societal openness may be related to greater advances in human development, greater gender equality, and greater tolerance toward variations in sexual behavior and identity.

18.5 Description of the Pornhub Websites and Their Source/Data Collection

The primary source of data for our glance at worldwide pornography use is known as PORNHUB (PHUB: pornhub.com). Based in Montreal, it is one of the most popular global porn websites and can be accessed generally by anyone having access to the internet, unless such websites are specifically blocked. A variety of language options exists for user interaction with this website.

We used data primarily from the past 3 years in review [32–34], along with information from the PHUB "information#privacy" link [35]. The general public can access the website as either registered or unregistered users. Unregistered users provide no disclosing information but have access to short length video clips of various genres (e.g., heterosexual, gay/lesbian, and hentai (animated)). However, they cannot download videos, and ads that might corrupt their device are not screened out. In contrast, registered users are entitled to membership perks that include: longer and full-length videos; higher technical quality videos such as 1080p HD or 4 K; ability to download files in HD; access to the 30,000+ library of full-length DVDs; no ads; improved security through better encrypted information when on the website; and cross-membership on other porn sites such as RedTube and YouPorn. Thus, registered users not only receive many more perks but also provide more information about themselves. The percent of registered to unregistered users is not discernible from the data reports, but PHUB reports that 22 million users were registered in 2017 [33].

18.5.1 Data PHUB Collects on Website Users

The website [35] collects different data on unregistered and registered persons. For unregistered users, the site collects technical data such as IP address (removing information in the working dataset that could identify a specific site or individual, thereby assuring anonymity), browser type and version, time zone setting and location, and device and operating system while on the website. In addition, any voluntary information the user submits, such as might be related to a contest or web-based survey, is recorded. And finally, usage data are collected, including amount of time spent on the site as well as linkage/time to specific portions/options/links within the website, such as time spent on a specific video and searches during the session.

Registered users create an account with PHUB, and therefore, in addition to the technical and usage information collected on unregistered users, data on username, date of birth, gender, contact, and financial transaction are collected. Submitted data regarding preferences, specific interests, feedback, and survey responses are noted, as well as marketing and communication data related to receiving emails, marketing notices, and contact from third-party vendors.

No personal data are shared, but other information is aggregated to create annual statistical reports that are released at the end of the year. Data include categories

such as traffic by countries, type of pornography and specific performers, time spent on the website, gender and age breakdown, devices and operating systems (such as Windows, Mac OS, chrome OS, etc.), and traffic during sporting events/TV events and holidays.

18.5.2 How PHUB Collects Data

PHUB collects data through a number of processes. These include direct interactions that occur while the person uses the webpages, such as search queries, filling out forms for surveys, or registering for the website. PHUB also uses automated technologies or interactions such as "cookies" and third-party analytics such as Google Analytics (cookies enable communication between the web server and the web browsers and are a part of most website visitations and are in fact required to operate many websites). PHUB uses three types of cookies: analytical, which allows counting and recognizing the number of users, and helps improve the users' experience by finding what they want; functionality, which enhances a person's experience on the website and allows recognition upon returning to the website; and targeting, which records the visit, the pages visited, and the links followed.

In addition to cookies, PHUB uses third-party analytics such as Google Analytics and DoubleClick (provided by Google Inc., USA) which collect IP addresses, device and software identifiers, website behaviors, and referring and exit URLS. If a user has an account with Google Services such as Google Plus or YouTube where gender and age are required, Google Analytics can link the Google profile to a site and, using browser history, can estimate the age and gender of the users.

18.5.3 Limitations of the Dataset

Obviously, users have access to a number of pornography websites, with PHUB being only one of several major access portals. As such, it captures only a portion of pornography use, and there are likely biases as to which portion it might capture (e.g., persons with certain native languages, etc.). Furthermore, specific parts of the world are underrepresented or not represented at all on PHUB website data, presumably because the information is sparse, the inability to adequately verify the information, or their website is specifically blocked. Furthermore, complete sets of data are not reported on all users, and therefore, some data may be affected by the ratio of registered to non-registered users. Finally, although *internet* pornography is among the most popular sources, it is not the only source, with videos, magazines, cable TV, and other sources available to users. Nevertheless, PHUB provides at least *one* window into worldwide pornography use, and it catalogs and analyzes data more extensively than is available through other sources. Having noted such limitations, the reader should view the following analyses as suggestive trends regarding worldwide pornography use without necessarily assuming they are rigorous and incontrovertible.

18.6 Pornography Use Among PHUB users

From 2016 to 2018, PHUB recorded 23 billion hits, 28.5 billion, and most recently, 33.5 billion, thus showing overall rapid growth in pornography use [32–34]. They further report that in 2018 the site had about 64,000 new visitors *per minute*. The top 20 countries in 2014 (the first year of such reporting) and in 2018 based on the number of overall visits (not adjusted per capita) account for about 80% of the daily traffic [36]. Box 18.1 lists the top 20 usage countries in 2014 and 2018, with information showing changes in ranks of various countries between the 4 years. Notable are the very large increases in rank in pornography visits in Japan and the Philippines, offset by relatively small decreases in 11 other countries, with Russia showing the largest decrease. Egypt and Romania, both on the 2014 list, dropped off the 2018 list. And Ukraine and South Africa joined the top 20 on the 2018 list.

Broadly speaking, users from Eastern countries spent more time per visit on the website than those from Western countries, with Middle Eastern and Asian users spending the most time *per visit* on the websites. Users from Pakistan, the UAE, Egypt, Qatar, Saudi Arabia, and India had the highest "bounce back" rate in 2018, signaling that they quickly enter and exit the websites, probably due to the perceived risqué nature of the behavior. Types of pornography vary across worldwide regions, with Box 18.2 providing a listing of the top types of pornography viewed in order of preference in 2018.

Box 18.1 Top 20 countries for PHUB visits based on total hits

2014	2018
1. United States	1. United States
2. United Kingdom	2. United Kingdom
3. Canada	3. India (+1)∗
4. India	4. Japan (+11)∗
5. Germany	5. Canada (−2)∗∗
6. France	6. France
7. Italy	7. Germany (−2)∗∗
8. Australia	8. Italy (−1)
9. Brazil	9. Australia (−1)∗∗
10. Mexico	10. Philippines (+9)∗
11. Spain	11. Mexico (−1)∗∗
12. Russia	12. Brazil (−3)∗∗
13. Netherlands	13. Spain (−2)∗∗
14. Poland	14. Poland
15. Japan	15. Netherlands (−2)∗∗
16. Sweden	16. Ukraine
17. Argentina	17. Sweden (−1)∗∗
18. Egypt	18. Argentina (−1)∗∗
19. Philippines	19. Russia (−7)∗∗
20. Romania	20. South Africa

∗Represents increase in rank; ∗∗Represents decrease in rank

Box 18.2 Linked Content in Order from Most Preferred for 2018

Preferred content/actor
Lesbian
Japanese
MILF
Ebony
Hentai
Anal
Mature
Threesomes
Big Tits
Big Dick
Amateur
Teen
Transgender
Creampie
Cartoon
Babe
Indian
Gangbang
Bondage

Table 18.1 Use by gender across regions, 2016

Region	Women	Men
Asia/Southeast Asia	27%	73%
USA/Canada	25%	75%
Western/Central Europe	26.3%	73.7%
Latin/South America	31.6%	68.3%
Africa (Sub-Saharan)	33%	67%
Middle East/Gulf Countries	NA	NA
Asian Subcontinent	30%	70%
Australia and New Zealand	29%	71%
Central Asia (Russia/the Stans)	27%	73%

NA not available: minimal or no information was available on countries in this region

18.6.1 General Patterns of Use Across Regions

To obtain a description of usage in various regions of the world, we aggregated country data from the PHUB website into nine world regions, and provide highlights of trends within those regions, including frequency of use, time spent on the site, and type of preferred activity or content. Regions were established primarily on the basis of proximity, but cohesion regarding cultural/religious backgrounds was also considered (see Table 18.1 for a listing of the nine regions). For regions where data were incomplete, we included subsets of countries that could provide at least a glimpse of that region.

East Asia/Southeast Asia (Including China) In this region, both the Philippines and South Korea increased greatly in rank in 2017, by 49 and 20 spots respectively, in line with a trend of growing usage in Southeast Asia. The Philippines was also among those countries showing the highest average times per visit, typically around 13 min; Thailand showed a large increase in average time per visit since the past year. Preferred content for this region was Hentai, that is, overtly sexualized animated characters.

Canada/USA Canada and the USA both fall within the top several countries each year. However, per capita data, which are only provided sporadically within the PHUB webpages, suggest relative usage rates much lower than some other countries/regions. The typical amount of time per visit was slightly over 10 min for these countries. For the past 3 years, the top search was Lesbian content.

Western and Central Europe Many European countries fell within the top 20 hits for the past several years, including France, Italy, Spain, and Germany. Again, however, when rank is adjusted per capita, many European countries ranked substantially lower. On average, visitors from these countries spent 8–9 min/visit. Preferred content was Teen, Lesbian, and Anal in 2016, and Anal, MILF, and Hentai (the last seen primarily in countries nearest Asia) in 2017.

Latin and South America Several countries from this region, such as Mexico, Argentina, and Brazil, are consistently in the top 20. Countries like Cuba and Columbia both showed notably high increases in rank by 26 and 17 spots, respectively. Average time per visit was about 12 min for South America. Preferred content over the 2016–2018 span included Anal, Lesbian, and Hentai.

Australia and New Zealand Australia was in the top 20 for the past 3 years, with an average time per visit of 9–10 min. Data for New Zealand were generally limited. Preferred content choice was Lesbian for the past 3 years.

Central Asia (Russia and the Stans) Russia has been among the top 20 usage countries, generally scoring in the lower tier. Time spent per visit for Russia was typically low, around 7 min. Pakistan and Kazakhstan had large rank increases in 2017 and 2018 respectively, 23 places for Pakistan, and 33 places Kazakhstan. MILF, Anal, Big Dick, and most recently, Lesbian, have led in content choice.

Sub-Saharan Africa Only minimal information is available on African countries, and only South Africa has appeared in the top 20, added to the list in 2018. Ethiopia showed a large rank increase of 68 places in 2017. The most popular content choice was Ebony where performers are typically black or persons of color.

Asian Subcontinent (Including India) India has been among the top 5 countries for the past several years—perhaps the result of its large population—with an average time per visit of about 8 min. Popular content choice included MILF, Lesbian, and Threesome in 2018.

Middle East/Gulf Countries/East Northern Africa Most of these countries are Muslim, but Israel is also included. However, due to restrictions on data collection and site access, information is scant and may be unreliable. None of these countries fell in the top 20. However, several countries such as Turkey, Syria, and Libya had large increases in usage rank, anywhere from 17 to 31 spots. Popular content choices included Arab, Anal, and Lesbian.

18.6.2 Use by Gender Across Regions

Tables 18.1, 18.2, and 18.3 provide information regarding PHUB use broken down by region and gender for the years 2016–2018. Not surprisingly, across all 3 years, use was male-dominated in all regions, a ratio of about 7:3. The USA/Canada, Western/Central Europe, and Central Asia showed the greatest difference in gender use, although women's use increased or held fast in nearly all world regions from 2016 to 2018, except Latin/South America, where it decreased slightly. Proportion of women's use was highest in sub-Saharan Africa.

18.6.3 Use by Age Across Regions

The mean age of PHUB users for 2018 was 35.5 worldwide. Tables 18.4 and 18.5 provide data regarding user age by region for the years 2016 and 2018. In 2016, about 28% of users were 18–24, 34% were 25–34, and 38% were 35 and older. In 2018, a greater percent of users (closer to 45%) was 35 and older, with Latin/

Table 18.2 Use by gender across regions, 2017

Region	Women	Men
East Asia/Southeast Asia	27.5%	72.5%
USA/Canada	25%	75%
Western/Central Europe	25.8%	74.1%
Latin/South America	31%	69%
Africa (Sub-Saharan)	32%	68%
Middle East/Gulf Countries	NA	NA
Asian Subcontinent	30%	70%
Australia and New Zealand	28%	72%
Central Asia (Russia/the Stans)	26%	74%

Table 18.3 Use by gender across regions, 2018

Region	Women	Men
Asia/Southeast Asia	31.5%	68.5%
USA/Canada	28.5%	71.5%
Western/Central Europe	28%	72%
Latin/South America	30%	70%
Africa (sub-Saharan)	35%	65%
Middle East/Gulf Countries	NA	NA
Asian Sub continents	30%	70%
Australia/New Zealand	30%	70%
Central Asia (Russia/the Stans)	27%	73%

Table 18.4 Use by age across regions, 2016

Region	18–24 yrs old	25–34 yrs old	35 and older
Asia/Southeast Asia	33%	34.5%	33%
USA/Canada	26%	31%	43%
Western/Central Europe	26%	31%	43%
Latin/South America	25%	37%	38%
Sub-Saharan Africa	37%	32%	31%
Middle East/Gulf Countries	NA	NA	NA
Asian Subcontinent	48%	28%	24%
Central Asia	23%	38%	39%
Australia/New Zealand	22%	36%	47%

Table 18.5 Use by age across regions, 2018

Region	18–24 yrs old	25–34 yrs old	35 and older
Asia/Southeast Asia	24%	36%	41%
USA/Canada	20%	31%	40%
Western/Central Europe	23%	36%	42%
Latin/South America	24%	36%	60%
Sub-Saharan Africa	22%	42%	36%
Middle East/Gulf Countries	NA	NA	NA
Asian Subcontinent	44%	41%	15%
Central Asia	17%	38%	45%
Australia/New Zealand	20%	29%	51%

South America, Australia/New Zealand, and Asia/Southeast Asia leading in this age category. In 2018, the percent of users in the 18–24 year range was fairly consistent over regions, with the exception of India, where a high percentage of users (44%) were 18–24, with 85% included in the 18–34 year range. In Russia, the Philippines, Sweden, and South Africa, 38–42% of the users were 25–34.

18.7 Relationships Between Pornography Use and Other Indices (Table 18.6)

To give further context to worldwide pornography use, we juxtaposed parameters of pornography use with a number of other indices drawn from WHO—the Human Development Index (HDI) and the Gender Inequality Index (GII)—as well as several other data sources. From these other sources, we calculated (i) a Trans/Homophobia Index (THI) based on visual mapping from the International Lesbian, Gay, Bisexual, Trans, and Intersex Association on sexual orientation laws in the world [37], and (ii) an Internet Use score based on the percentage of the population within a region that uses the internet [38].

Specifically, the *HDI* represents three broad constructs, each defined quantitatively; these include a long and healthy life (longevity), knowledge (an education index), and a decent standard of living (per capita income). The HDI is expressed as a number between 0 and 1.0, with higher scores indicating higher levels of human development (and vice versa). The *GII* is comprised of three components:

Table 18.6 Relationship between pornography use and sociocultural indices

Region	Top-20 relative position	Percentage female use	Type of pornography first, second, third preferred	Human development index	Gender inequality index	Trans/ homophobia index	Internet use
Asia/SE Asia	2.00	30%	Hentai, MILF, Lesbian	0.83	0.22	4.0	47%
USA/ Canada	1.00	25%	Lesbian, MILF, Ebony	0.93	0.14	2.5	84%
Western and Central Europe	1.50	26%	Lesbian, MILF, Mature	0.91	0.09	1.4	82%
Latin and South America	1.75	31%	Lesbian, Anal, Hentai	0.78	0.35	1.5	57%
Sub-Saharan Africa	3.00	32%	Ebony, Lesbian, MILF	0.45	0.62	4.2	20%
Middle East/Gulf Counties	3.00	N/A	Arab, Anal, Lesbian	0.76	0.60	4.6	59%
Asian Sub-Continent	1.00	30%	MILF, Lesbian, Threesome	0.61	0.51	3.7	36%
Austria and New Zealand	1.00	28%	Lesbian, MILF, Threesome	0.93	0.12	1.0	87%
Central Asia	2.25	27%	Hentai, MILF, Anal	0.71	0.30	3.8	76%

Notes: N/A: Little to no information was available on Pornhub on countries in this region. *Top-20 Position* ranges from 1.0 to 3.0, with 1 = in the top 20, 2 = partly in the top 20, 3 = not in the top 20. *Human Development Index* ranges from 0.0 to 1.0, with greater values indicating greater human development. *Gender Inequality Index* ranges from 0.0 to 1.0, with greater values indicating greater gender inequality. *Homophobia Index* ranges from 1.0 to 5.0, with greater values indicating greater trans/homophobia. *Internet Use* indicates the percentage of the population that uses the internet in that specific region

reproductive health, empowerment, and the labor market. Reproductive health indicators are maternal mortality ratio and adolescent birth rate. Empowerment is represented by the share of parliamentary seats held by women and share of population with some secondary education by gender. The labor market is indicated by participation in the labor force by gender. The value of GII ranges between 0 and 1.0, with 0 being 0% inequality, indicating women fare equally in comparison with men and 1 being 100% inequality, indicating women fare poorly in comparison with men. The THI is based on data presented in a map on State-Sponsored Homophobia, an ILGA report by Lucas Ramón Mendos (ilga.org). The map distinguishes among a number of categories of tolerance, ranging from protection against discrimination to criminalization of consensual same-sex sexual acts. For our purposes, these categories were compressed into 5, ranging from 1 = protection, 2 = limited or uneven protection, 3 = neutral, 4 = some criminalization, 5 = harsh criminalization [10 years

to execution]). Ratings represent a general regional average. Finally, the Internet Use score was represented by a percentage between 0 and 1.0, with higher scores representing greater access.

Using the Kendall's tau b non-parametric correlation procedure, we analyzed whether position in or out of the top 20 (1 = yes; 2 = partly; 3 = no, with regions represented by the average of the constituent countries) was related to the various regional sociocultural indices. We also tested whether the percent of female usage for a region was related to these indices (Table 18.6).

Several associations emerged. Higher overall use was correlated significantly with higher HDI ($r_t = 0.59$, $p = 0.053$) and lower homophobia ($r_t = -0.65$, $p = 0.019$). Higher percent of female usage was significantly correlated with lower HDI ($r_t = -0.59$, $p = 0.044$), lower gender equality ($r_t = -0.62$, $p = 0.034$), and lower Internet access ($r_t = -0.62$, $p = 0.034$). Several of the indices themselves were correlated. For example, the HDI was negatively correlated with the Gender Inequality Index ($r_t = -0.70$: higher HDI score meant lower Gender Inequality) and positively correlated with Internet Use ($r_t = 0.65$), and the Gender Inequality Index and Trans/Homophobia Index were positively correlated ($r_t = 0.56$: the higher the gender inequality, the higher the trans/homophobia).

18.8 Discussion of General Trends

Limitations of the available data on PHUB place restrictions on the strength and validity of the conclusions that might be drawn. The focus of the data on the top 20 countries based on overall number of visits, along with the lack of comprehensive per capita based data, makes country-to-country comparisons difficult. In addition, the lack of detailed information on lower usage countries makes it difficult to discern patterns within those regions. Indeed, one confounding factor affecting visits to PHUB is that of internet access, which varies widely across regions of the world, and tends to be lower in developing and least developed countries [39]. Nevertheless, we were able to discern several interesting patterns.

18.8.1 Trends Across Regions of the World

We begin by noting that most countries in the top 20 have well-developed infrastructures—regions such as Western/Central Europe, North America/Mexico, and portions of South America and Asia. However, *changes* in usage provide clues regarding *trends* in pornography use. For example, we note that two Asian countries—Japan and the Philippines—entered the "top 20" club in 2018, reflecting apparent rapid growth in usage in that world region and further buoyed by South Korea's large increase in rank and Thailand's large increase in the amount of time spent per visit.

A second notable pattern was the rapidly increasing use of internet pornography in developing and less developed countries/regions, even in regions that have strong

religious strictures against pornography use. Islamic countries such as Pakistan, UAE, Egypt, Qatar, Saudi Arabia, and Hindu countries such as India showed the highest bounce back rates in the world (suggesting risk/fear of getting caught), yet Pakistan, Kazakhstan, Turkey, Syria, and Libya all showed large rank increases during 2017–2018. Visitors from Middle Eastern and Central Asian countries spend the most time per visit overall on the websites, and India has been consistently appearing among the top 5 user countries.

Whereas selection of particular actors of color (Ebony, Indian, Japanese) is readily understood, somewhat surprising is that Lesbian was among the top preferred content choices, and Transgender appeared in the top 13. Whether such preferences stem from curiosity, erotic value for both heterosexual and homosexual individuals [40, 41], or particular user characteristics is not determinable from the data, but nevertheless raise interesting questions regarding user demographics.

What might we conclude from such trends? Primarily that Internet use is growing rapidly across all cultures and in all parts of the world, and will probably continue to do so as Internet access/use increases in various parts of the world. Furthermore, the idea that individuals from specific geopolitical regions or from specific religious traditions have not been exposed to, or are less vulnerable to the alluring effects of, pornography can no longer be assumed. Furthermore, based on content preference, users are regularly being exposed to variations in sexuality that, 10–15 years ago, would have been considered marginal, deviant, and generally unthinkable. Indeed, such behaviors are probably often not within the users' own (or peers') sexual experiences and yet may, because of their frequent portrayal in pornographic material, lead some to conclude that such activities represent normative behavior (e.g., group sex, anal sex, inflicting pain, and so on).

18.8.2 Trends Related to Gender, Age, and World Region

Interestingly, about 28% of users are women, with—as of 2018—even higher proportions in Africa, Latin America, and Asia. Furthermore, a general trend since 2016 indicates that women constitute an increasing segment of internet pornography users throughout the world. Finally, the relatively frequent use by 18–24-year-olds suggests that young adults—whose sex lives may be as yet uninitiated or still in formative development—may be unduly influenced by pornography exposure. As indicated in studies from several developing nations, internet pornography may be a major source for sex education for some youth; and in fact, it may be the *only* source of sex education for many young adults [15, 16]. And this phenomenon may also extend to viewers under the age of 18, as only recently have measures been implemented to attempt to verify users' ages on pornography websites such as PHUB.

In many countries or regions of the world, no formal sex education is offered to youth; in other regions, sex education may be handled informally through family members or friends, but such information often lacks accuracy and may be strongly culturally influenced (see Ch. 1 in this volume). For this reason, exceedingly easy

access to pornography may raise an alarm, as it may be the only education regarding sexual activities, sex roles, and expectations that young men or women receive. Given the potentially skewed perspective imparted by such exposure, the need for formal sex education that promotes healthy sexuality and relationships becomes critically important. Indeed, authors of various chapters in this book from around the world (see Chaps. 3, 8, 9, and 11) lament the inadequate or absent sex education for both youth and professionals in their cultures/regions/countries. Perhaps the most cogent argument for sex education—long seen as an invitation for adolescent sex in many cultures—might now be that it provides the better alternative to the growing prevalence of non-intentional pornography-based sex education.

18.8.3 World Regional Trends Related to Various Sociocultural Indices

Several relationships among indices were to be expected, others raise new questions. For example, the finding that pornography use and internet access were related is neither surprising nor novel. Also as expected, pornography use was associated with greater human development (health, knowledge, and standard of living) and lower homophobia, generally affirming that more advanced and well-off societies tend to be more tolerant of sexual diversity and, along with it, pornography use. Perhaps less intuitive was the finding that greater female use within a region was associated with greater gender inequality and greater trans/homophobia. This finding, together with the pattern of preferred lesbian content in a number of regions, may support the idea that, at least for some instances, individuals on the sexual margins (trans, gay, lesbian) may disproportionately rely on internet pornography both for a sense of validation/group identity, and for sex education (see Chaps. 4 and 7 for discussion of such assumptions). Such findings suggest that although widespread access to internet pornography has potential liabilities/downsides, in some instances it may serve important functions, especially for those individuals who may feel outside the sexual conventions within their social systems.

18.9 Conclusions and Implications for Practice

Perhaps the most important implication for practitioners is the recognition that online pornography is used by a wide variety of individuals throughout the world, both men and women as well as young, middle-aged, and mature adults. All religious, ethnic, and racial groups appear to participate in this activity. Although access may be driven by the erotic value of the content, in many instances pornography may satisfy curiosity and serve an educational role. Practitioners should recognize, therefore, that what men and women perceive as usual and customary may have been derived from their experience with pornography; such information might range from sexual position and type, technique, relationships between the sexes, racial and sexual stereotypes, and what is deemed pleasurable and desirable. In fact, an individual's understanding of sexuality based on pornography viewing vs. the

actual reality of sexual intimacy with a partner may be quite disparate, with young viewers not recognizing the fantasy world that pornography is often intended to create. Thus, men and women from many parts of the world may have little or no information regarding sexuality, or alternatively they may have grossly *inaccurate* information regarding sexual acts, intimacy, and relationships derived from pornography use.

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Cross Cultural Research: Opportunities and Strategies for Discovery

19

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19.1 Introduction: Culture and Sexuality

Culture is represented by the culmination of social behaviors and norms assumed by human societies and, at least in the past, is often tied to geographic regions or specific populations. Due to increasing internationalization and global mobility, cultural boundaries tied to geographic regions are eroding, and cultures themselves are increasingly sharing more common elements [1]. Culture typically has both material and immaterial expression: Culture is often defined most strongly by principles of social organization, beliefs, and myths of origin (immaterial), but may also be strongly influenced by the local environment, including terrain, resources, climate, and so on, thus being manifested materially in specific forms of music, dance, art, religion, food preparation, style of eating, architecture, house decorations, dress, etc. [2]. Elements of culture, sometimes referred to as *memes*, are encoded and integrated in our minds in some still unknown manner [3], to be passed from one individual to another (intra or inter-generationally) primarily through imitation and learning. Yet, despite increasing internationalization, even within the same society, social classes and various lifestyles may distinguish one subculture from another.

Culture may affect sexuality at different levels, for example, at the societal level, the individual level, and even the anatomical/biological level. At the societal level, some social systems allow one man to marry multiple women, though not vice versa; some accept homosexuality, even as a representation of family, others punish it with death [4]; and some permit pre-marital sex and/or masturbation while others

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place prohibitions on them. As an example, abstinence is viewed quite differently across cultures. For some cultures and subcultures, abstinence entails refraining from all types of sexual acts. For others, abstinence refers only to intercourse, with group members still permitted to engage in kissing, cuddling, or holding hands. In some cultures, masturbation is banned on religious grounds, while others see masturbation as relatively harmless and, in some cases, even beneficial [5, 6]. The social system may also dictate very different social/sexual scripts and norms for men and women, for example, in terms of what is allowed before, during, and after (e.g., death of spouse) marital conjugation.

At the level of the individual, culture may identify what behaviors during partnered sex are expected and/or permissible. Kissing on the mouth in Western society is a basic source of sexual arousal, but this practice is uncommon or absent in many other cultures. Foreplay, the physical sexual interactions between partners (romantic kissing, sensual touching, fondling) occurring before intercourse, is generally brief in Western cultures, although continued for some time through intercourse. In contrast, some Eastern societies prefer an extended foreplay in order to prolong states of sexual arousal [7]. Some cultures (Western world, parts of Asia, and many South Pacific island societies) largely accept oral sex (as a specific/derivative sexual act, or as a component of sexual arousal and foreplay), while other cultures (e.g., much of sub-Saharan Africa) consider it highly unnatural and/or sinful.

Culture may even guide what is anatomically acceptable. These days, the significance of the hymen is more cultural (as a symbol of purity and virginity) than physiological (to cover the vaginal opening in order to protect the vagina). In China and areas where the Islam religion predominates, virginity is highly prized such that women may resort to surgical interventions (hymenoplasty) to reclaim their virginity; indeed, an important role for the penis in some cultures is that of rupturing the hymen as part of the wedding night ritual. Male circumcision, discussed in biblical texts, is largely ritualistic and culturally based, although some research suggests that it may assist in maintaining genital hygiene and reducing sexually transmitted disease [8, 9].

Given the wide influence of culture on socio-sexual norms, individual sexual behavior, and the meaning of genital anatomy/biology, opportunities for cross cultural sexual research abound, extending from the biomedical and psychological to the sociological, anthropological, theological, and legal. Sexual issues such as gender, orientation, socio-sexual scripts, sexual response and impairment, distress, and satisfaction—all relevant to sexual medicine—would benefit from cross cultural perspectives that inform clinical practice.

19.2 Culture as a Variable in Sexuality Research: Methodological Perspectives

Although the call for cultural competency and expansion is decades old, the manner in which cultural differences should and could affect practice in sexual medicine is not widely documented and disseminated. To be sure, in our opinion, the problem stems not from a lack of research on topics relating cultural differences to sexual

traditions and practice, but rather from a lack of translation of relevant information into manageable bytes that can be easily consumed, interpreted, and adapted to a clinical environment.

Box 19.1 Key Issues

- Cultural variables impact both sexual beliefs/practices and access to sexual healthcare
- The impact of cultural differences on clinical practice in sexual medicine needs greater attention.
- Inclusion of culturally relevant variables is often lacking in standard research protocols.
- Medical studies often focus on bio-psychological variables to the detriment of understanding the potential influence of socio-cultural variables.

Previously we posited that understanding broad relationships between variables could benefit by studying *dirty* samples [10]. That is, samples that use *fewer* rather than more exclusion criteria may help bring clarity to the overall relationships between two or more variables, and, when samples are sizable, may provide opportunity to examine the influence of specific (often excluded) variables on outcomes by including the factor as a covariate in the analyses. The context for this argument was made in relation to the study of sexual dysfunction in the mentally ill, where linkages between sexual and psychological disturbances appear not only interesting and specific, but more than merely coincidental [11]. Studies dealing with sexuality routinely screen out individuals with mental health issues. In fact, a better approach might include both mentally healthy and mentally ill participants, and assuming sufficient numbers in the sample, treat these and related conditions as relevant covariates.

A similar approach might apply to the study of sexuality and cultural differences. A long-standing strategy in clinical research has been to study variation in outcome variables by using "clean" samples, as manifested by long lists of exclusionary criteria. Such an approach has a clear advantage: It increases the chances of detecting real effects or relationships between two or more variables. Within an experimental design (as might be used in a randomized, placebo-controlled trial), the strength of the detected effect can be conceptualized as the ratio of signal to noise, with the predictor or independent variable effect representing the signal or explained variation, and noise representing random or unexplained variation. Clean samples help ensure a low level of "noise," thus providing a greater signal-to-noise ratio. In a correlational design, the ratio that generates "r" is slightly different, perhaps most easily conceptualized as the ratio of the co-variance of x and y (or explained variation) to the total variation (of both x and y). As might be apparent, the greater the explained variance to the total variance, the greater the value of r, and ultimately r^2, the index representing the percent of explained variation.

Although some exclusionary variables in research ensure safety and compliance, many restrictions on *subject* variables (i.e., those characteristics that reside within

the subject, such as depression, sex, disease, age, and so on) are implemented for the sole purpose of increasing sample homogeneity and thereby reducing noise. But this approach has a well-known and serious shortcoming. The "cleaner" the sample, the less generalizable the results to the wider population, as the results apply only to the population that shares the characteristics of the sample. The flaw in such an approach became evident as researchers studying various pharmaceuticals came to realize that such factors as age, sex, race, and ethnicity significantly impacted drug effectiveness. As a result, most regulatory agencies (e.g., Food and Drug Administration of the USA) now mandate the presentation and inclusion of analyses of demographic data in marketing applications [12]. Furthermore, the FDA notes that if there is a reason to believe any particular subgroup might respond differently to a drug, the studies should account for and plan, *a priori,* how to design clinical trials to capture such differences.

19.3 Culture as a Variable in Sexuality Research: Conceptual Considerations

19.3.1 The Biological-Individual

Sexuality involves a strong biological component [13] and thus most would agree that inclusion of relevant biological variables is useful in assessing the effects of treatment variables. Inclusion of race, ethnicity, age, and sex—all factors having biological origins—are important in pharmaceutical research on sexual issues, even though their inclusion increases heterogeneity of the sample [14]. Indeed, such heterogeneity becomes a strength when generalizing results to larger populations and aids in the process of developing precision medicine [15]. Nevertheless, in today's world, sexuality has deviated substantially from its original biological purpose of procreation via a myriad of cultural and/or social interests that have little relevance to procreation. Sex serves purposes such as bonding, intimacy, and in many instances, a means for achieving family or community status and/or other cultural or social goals (e.g., religious, professional and personal gain, etc.) [16, 17]. Thus, even though sexuality is a biologically-driven behavior having its origins in reproduction, sexuality is as much socio-cultural as biological, and therefore to study sexuality in isolation from culture is to ignore relevant factors having, in some instances, potentially large influences.

19.3.2 The Socio-Cultural

The specific cultural particularities presented in Sect. 19.1, as well as numerous unmentioned ones, have a direct impact on (and interrelation with) sexuality. These social-cultural factors/influences should *both* be studied and interpreted separately from the biological-individual systems, *and* studied as part of a larger integrated system, recognizing that social-cultural factors on the one hand and

biologic-individual factors on the other manifest bidirectional and reciprocating influences on one another [18, 19]. Specifically, the interactive nature of the biological-individual and socio-cultural further argues against studying such factors in isolation from one another.

19.4 A Rapprochement

19.4.1 Neural Integration of the Sexual Self/Response

Many sexual processes having their roots in biology involve autonomic/involuntary systems, for example, vasodilation-erection, lubrication, and orgasm-ejaculation. At the same time, many sexual processes are under voluntary (somatic) control, such as defining and seeking out a sexually interesting/desirable partner, engaging in foreplay, recognizing appropriate situational factors, and so on. All such processes—whether biologically or culturally/experientially grounded—are represented and integrated within specific cerebral neural substrates—in the entity we might call the *mind*—to ensure a well-coordinated and unified sexual response [3, 13, 17, 20].

19.4.2 The Implications of Neurobiological Integration

Given the interwoven representation of sexuality in the brain, it is unlikely that, once integrated through learning, maturation, and experience, the biological and socio-cultural representations of sex can be easily disentangled. Consider sexual arousal at the genital level, largely a biological process, which is ultimately dependent on cognitive/emotional sexual arousal, a process that is largely defined culturally: what men and women find psychologically attractive and arousing varies from one culture to the next. Thus, the neural representation of sexuality—a collaboration of the autonomic and somatic systems, of the biological-individual and socio-cultural—is likely to differ substantially across cultures.[1] While the biological-individual and the socio-cultural may be studied in relative isolation from one another to identify relevant components/factors, the study of sexuality *in situ* would, in our view, benefit more from a holistic approach that includes relevant factors from both domains. In other words, we would argue that the study of inadequate arousal in women, or erectile problems due to anxiety in men, cannot really be fully understood without an understanding of the cultural context in which they occur.

[1] This situation is further complicated by the fact that the mind itself has an autonomous character, capable of working with and manipulating internal stimuli and developing internal responses, which may not necessarily be externalized (think of a sexual fantasy leading to the feeling of being psychologically aroused but with no evident physical response)

19.4.3 Understanding the Relative Weights of Biological/ Individual vs Socio-cultural Factors

One way of conceptualizing sexual response in men and women has been provided by Bancroft et al.'s dual control model [21], which posits that sexual responses involve an interaction between sexual excitatory and sexual inhibitory processes. The model further postulates that individuals vary in their propensity for both sexual excitation and sexual inhibition, and that such variations help us to understand much of the variability in human sexuality. Excitatory and inhibitory factors can be biological, psychological, and/or cultural, and while studies have attempted to assess each of these various domains, understanding the relative weight of cultural factors across different kinds of social systems has not been addressed; nor have studies shown how addressing one domain (e.g., using pro-erectile medications such as PDE-5 inhibitors) might affect inhibitory/excitatory factors within another domain. For example, those living under social systems that impose heavy constraints on sexuality through the education system, social and cultural norms, moral landmarks, and self-skills might have greater difficulty overcoming biologically-based inhibitions involving erection in men and/or arousal/desire in women. In contrast, those living in less restrictive socio-sexual systems might experience greater (or lesser) success in response to medications aimed at increasing erectile response or psychosexual counseling addressing issues of desire/arousal in women. Indeed, in our own study with men from the Asian subcontinent region, we have found that a surprising proportion of the men taking PDE-5 inhibitors for erection problems found them to be relatively ineffective, begging the question as to whether cultural factors were playing a role.

In summary for this section, we make two simple points. First, sexuality and response in any given individual is the product of biological, psychological, and cultural factors, and to study them in isolation may render an incomplete and perhaps distorted picture of the issue/problem. Second, the relative impact of socio-cultural factors on sexual response is largely unknown, with few studies comparing interventions for men and women who originate from cultures imposing very different restrictions on sexuality and its expression.

19.5 Approaches to Research

The practice of sexual medicine is as much a social science as it is a science of anatomy, physiology, and biochemistry. We identify two areas of inquiry related to sexual health that need urgent attention, each having its own challenges and benefits and both having broad implications for the social and medical sciences. Both areas mentioned here necessitate greater understanding and integration of the biological-individual and the socio-cultural aspects of sexuality.

19.5.1 Experiences Related to the Healthcare System and Clinic

The first area relates specifically to how patients and clients from different cultural backgrounds experience healthcare delivery systems, especially as they relate to issues surrounding sexuality. A number of studies have begun to explore and identify sex-related issues that impact access to and experience with health care systems, including the reluctance or shame that prevents accessing sexual health systems in the first place, or that inhibits clients from raising problems about sexual health during clinic visits. While many such challenges have been identified, including some discussed in this book, clear strategies that help practitioners and health organizations address the problems are often lacking.

Exploration of such issues requires practitioners and providers to think like and/or collaborate with social scientists to devise a methodology and process that gathers systematic data from various stakeholders in a non-threatening and unbiased way. Many social scientists, we believe, would enthusiastically seize the chance to collaborate on studies that assist vulnerable populations on sexual health related issues, whether regarding reproductive health, sexual identity, sexual performance and dissatisfaction, sexual relationship problems, and/or even domestic abuse. Several approaches are briefly discussed in the next sections.

19.5.1.1 Focus Groups

Mull [22] suggests viewing the GP's office as a potential research site. For clinics that deal with significant subpopulations belonging to an ethnicity or subculture (e.g., a clinic that serves sexual minorities), gathering several patients or non-patients together for focus groups can often reveal concerns that staff and healthcare personnel might otherwise overlook. As examples, Asian populations generally prefer an authoritative approach over a collaborative one; men in most cultures feel that admitting to a sexual problem or even STI is shameful or a sign of weakness and/or failure; Hispanic women may not know the terminology or language necessary to talk about particular sexual issues; and women in some cultures are not permitted to discuss sexual issues openly or with healthcare providers of the opposite sex.

Focus groups have been used successfully as a means of drawing out attitudes and feelings from various subpopulations, particularly when members of the subculture and/or vulnerable population are able to discuss their issue in a safe place [23]. Often such sessions begin with very broad, open-ended questions, such as the one provided in the study cited above: "Looking back at your life, living in both Iran and the US, how do you make sense of your sexual-self." Obviously, the sorts of questions related to healthcare might take a different form, such as "As a person from xyz (or with a xyz heritage), looking back at your experiences with healthcare in this country/region, describe your experiences—positive and negative—your concerns, and desires regarding healthcare issues surrounding sexual health…" Systematic collection of data with identification of major themes and recommended actions could provide a valuable topic for presentations or workshops at professional conferences

on sexual medicine and, assuming the information is new and clinically relevant, could lead to publishable manuscripts. Challenges might include finding and gathering men and women to participate in such groups (as their culture may discourage or even punish participation in such conversations), finding ways to encourage self-disclosure, and identifying themes that are not merely the result of group "echoing" but rather dominant perspectives that represent the broad spectrum of issues within the subculture.

19.5.1.2 Post Visit Surveys

A second strategy capitalizes on a clinic procedure often already in place. Many clinics in the USA send a short electronic post-visit survey to the patient regarding the perceived quality of and satisfaction with services rendered. Such surveys could easily include questions related to patient-centered care, particularly regarding sensitive issues such as sexuality. Again, working with a professional social scientist or survey constructionist, a question that asks the healthcare recipient whether he/she might want or benefit from future discussion/direction about any number of sensitive (often stigmatized) topics could be revealing. Such topics might include "sexual health" as part of a larger list that includes: drug use and addiction, depression, forgetting and/or cognitive deterioration, counseling, family relationships, domestic abuse, and so on. For patients responding, "sexual health," subcategories might include STIs/AIDS, safe sex, contraception, sexual response problems, sexual pain, sexual identity (orientation, gender identity, etc.), disability, sexual abuse, and so on. Anonymity—so identified as part of the survey—might result in greater self-disclosure and help medical staff better understand the types of problems on the minds of their patients. Such information could lead to greater sensitivity, awareness, and proactivity in future visits, particularly if done in conjunction with posted notices in clinic rooms that invite patients to discuss these kinds of sensitive issues. Such data from medical practices in various parts of the world could greatly assist in identifying underreported concerns—including sexual—due to stigmatization, embarrassment, and shame. Challenges might lie in a lack of literacy and/or access to electronic media (often the vehicle for post-visit evaluation), especially for vulnerable populations that might benefit most from such information—for example, underage women in poor economies who might be experiencing sexual abuse.

Box 19.2 The Research Agenda

- Both clinics and research groups could readily implement projects designed to increase understanding of the role of cultural variables in sexuality.
- Research studies might focus on the sexual healthcare experiences of culturally diverse subpopulations as well as basic information about sexual issues within those groups.
- The role that social media might play in affecting cultural sexual norms is largely unknown, but practitioners of sexual medicine need to be informed and prepared for future scenarios.

19.5.1.3 Pre-Visit Questionnaire

A third strategy, also expanding on procedures typically in place in GP or specialist offices, is to move relevant data gathering to the office pre-visit questionnaire. Most medical offices ask patients to update their medical information annually prior to an office visit, some questionnaires being sent and submitted electronically prior to the actual visit. This strategy is suggested by several authors in this book (Fuller, Chap. 4; Rashidian et al., Chap. 10) and in our view, would provide the patient the opportunity to identify concerns or issues beforehand—especially when those concerns are not explicitly identified as part of the reason for the visit. For example, many men do not identify a sexual issue as the reason for an office visit, as they are reluctant to disclose such information to the office staff—though it may well be on the patient's mind as something for discussion during the office visit. Having a question such as the one described in Sect. 19.5.1.2 for the post-visit survey evaluation could normalize (destigmatize) the problem for the patient and increase the probability of his/her raising the issue during the visit. Again, challenges occur for patients whose families accompany them to the clinic, for those having native language difficulties, and/or those already predisposed against raising various issues related to sexual health (e.g., unmarried women wanting contraception).

Above we list only several possible ways of encouraging greater communication during office visits. Such procedures could not only improve healthcare quality within individual clinics, but the data, when presented on an international platform (conference, publication), could be useful in encouraging practitioners to reflect upon and implement ways to improve patient-centered care and communication for culturally diverse subpopulations.

19.5.2 Basic Information About Sexual Issues in Understudied Subgroups and Cultures

As more countries adopt the Western standards of higher education, academicians and clinicians the world over are contributing ever increasingly to the volume of sexual knowledge and research in various populations and cultures. To our disappointment, many such studies appear to conclude that whatever phenomenon is under investigation also applies to the particular population in question. Often lacking is a deeper analysis of how and why cultural issues may or may not impact the phenomenon, as well as the direct implications the findings have for practice and healthcare services.

Our own experiences in this regard might prove fruitful for others. One of us (DLR) has established an international collaborative program with psychologists on the Asian subcontinent—with major benefits realized at both ends. The US team gains access to populations and data where social and sexual scripts differ substantially from those of Western culture—allowing for exploration of new issues and testing new hypotheses. The South Asian team benefits from having access to the latest resources (e.g., databases), assessment instruments, and statistical tools/expertise, as well as improved proficiency with writing and the publication process.

The learning gains on each side have been extensive, with Westerners better understanding written and non-written cultural values related to sexuality, and non-Western counterparts better understanding the rationale for Western thinking and the publication process.

The research agenda for such collaborations is jointly developed, with both sides proposing concepts for exploration—from the non-Western side, often ones specific to the indigenous population and its needs; from the US side, often well-tested ideas that could benefit from subcultures having values different from the West. In a manner somewhat parallel to patient-centered healthcare, our approach is "participant" centered research, where many of the issues are defined by members of the culture under study. In our case, this is often easy to do, as clinical psychologists—through their case work—are typically in touch with the concerning sexual issues of the local population. In each case, the South Asian team helps adapt the research question, strategy, recruitment, and data collection process to the local population.

Beyond psychologists, many others are positioned to provide insight into the regional culture regarding sexuality, including urologists, psychiatrists, gynecologists, and GPs, as well as anthropologists and sociologists from the region, as all have engaged with South Asian populations on a variety of issues regarding sexuality. Even when issues seem bio-medically straightforward and the use of pro-sexual medications is recommended, understanding of cultural interpretations can be valuable. The concepts of both "sexual distress" and "sexual satisfaction" are socially constructed [24] as is the meaning/interpretation of "sexual dysfunction" itself [25], as noted so well in the chapters in this book by El-Sakka (Chap. 8) and Hall (Chap. 12)—where subcultures may view vaginas as forbidden enclaves even to the women who "possess" them, and penises that do not cooperate may fail not only the spouse but also the extended families of the bride and groom.

Our own research on the use of cognitive behavioral therapy (CBT) in men with ED in Pakistan demonstrates the point well. We found that men with ED using a PDE-5 inhibitor to improve erectile response showed overall better erectile gains and greater sexual satisfaction when CBT was incorporated into the therapeutic process with the beneficial effects of CBT continuing as long as 1.5 years out [26, 27]. Specifically, these studies demonstrated that CBT can be an effective tool in helping men having cultural heritages radically different from the West deal with sexual problems. Specifically, the use of CBT as an adjunct therapy requires patients to embrace strategies that address larger (i.e., beyond genital) issues surrounding their sexual impairment, and that they learn to employ techniques developed primarily within a Western context of psychotherapy, an approach that has generally not been strongly endorsed ideologically or supported with resources in many developing nations. Yet, despite the substantial differences in gender/sex roles, religious expectations, and cultural values of Pakistan, this study demonstrated that CBT has both cross cultural value and efficacy. In an 18-month follow-up, which showed lasting benefits to improved sexual response, we posited that psycho-behavioral strategies exposed men to a completely different way of framing and addressing not only their sexual problem, but also the negative emotional and often self-defeating consequences that may accompany it. Such approaches may well

present a novel framework for these men, as such strategies are rarely in the forefront of medical or media discussion in countries such as Pakistan. In another set of studies addressing women's sexual issues in the Asian subcontinent (where sociosexual scripts are radically different from those in the West), we are exploring issues of women's self-blame and depression within relationships where either partner is experiencing a sexual performance problem [28–30]. We use these projects as but two examples of how cross cultural research can yield insights into biopsychosocial processes that might not otherwise be gleaned from studying sexual phenomena within a culturally homogenous environment.

To be meaningful, research need not necessarily be carried out across borders, as demonstrated by the work of Rashidian and colleagues [23]. As stated by one researcher, "…multicultural countries can also benefit from research which explores the role of culture in the messages, understandings, and constructions of sexual health and wellbeing for 1.5 generation migrants" [31] That is, not the conventional first generation migrants, who are old enough to emigrate on their own, nor the conventional second generation migrant, but rather the offspring of the first generation migrant born in the country of emigration. Such cohorts include people who left their country of origin and migrated to another country before completing puberty/adolescence. Study of these groups could highlight key socio-cultural areas which need to be addressed in young people who were born into one culture and are completing puberty in another. To this end, the migrant voices and understandings should be included in the development of education and services, the appropriateness and implications of policy, and service delivery and health promotion [32].

Cross cultural research is highly rewarding, but the challenges are many. Blindly and blithely establishing cross cultural research programs may well lead to futility and frustration. Institutions of higher education in the West generally build in an expectation and time for research; faculty and clinicians in other parts of the world often have little time for research, despite an expectation to do so. Those faculty may have no time off during the summer, no released time from teaching for research, no sabbaticals, and so on. Data collection is often tied to master's theses and doctoral dissertations in these countries. Yet despite the fact that data are continually being generated somewhere for some thesis, those data are often buried in archives and never made public—the result of insufficient time and resources as well as lower priority for research and publication. Yet, such conditions we believe make for potentially fruitful collaborative opportunities.

Other challenges may arise in the recruitment and data collection processes. In some cultures, discussing and/or disclosing about sex by women is considered taboo, dishonorable, and even sinful, and therefore participation in research efforts may be discouraged, with biased samples likely. Participants are more likely to be urban-dwelling, more educated, and less traditional in their religiosity. We further found, for example, that because health care in urban areas is superior to rural locations, many individuals seeking (sexual) health care temporarily reside in urban areas during treatment, often returning to their homelands where they may be inaccessible to the practitioner and/or researcher for further contact or follow-up.

19.6 Conclusion and Future Direction

The time is ripe for greater understanding and investigation of the impact of cultural differences on the practice of sexual medicine, doing so in such a way that informs clinical interactions, communication, and care. At the same time, the future holds many new and interesting possibilities for exploration. Sexual-cultural evolution is an ongoing process, undoubtedly increasingly affected (and perhaps accelerated) by social networks and media that not only influence the nature of sexual relationships but also alter traditional sexual expectations. With increasing access to erotica, medications, and information about changing/evolving social/gender norms in various parts of the world, the forces for retaining the status quo and forces for change are likely to become increasingly disparate—with potential psychological and sociocultural effects on individuals and society as well as political ramifications. Sexual medicine, more than most other areas of medical practice, needs to be both informed and prepared for such future scenarios.

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