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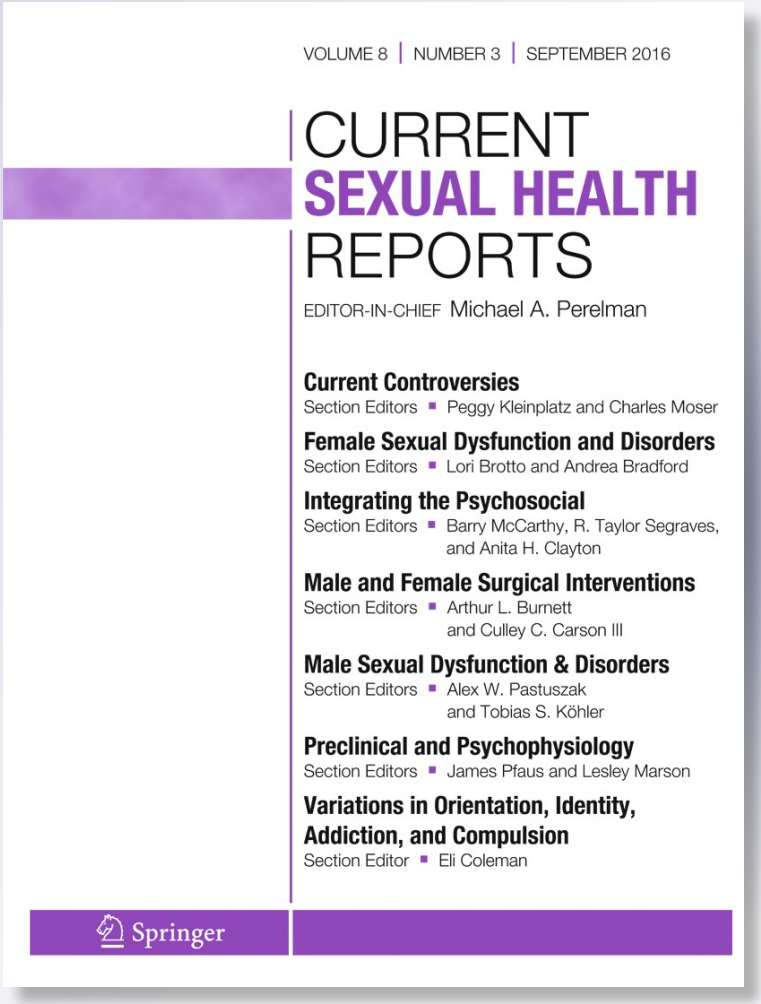

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FEMALE SEXUAL DYSFUNCTION AND DISORDERS (L BROTTO AND A BRADFORD, SECTION EDITORS)

The Impact of Culture and Ethnicity on Sexuality and Sexual Function

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Abstract
Introduction The biopsychosocial paradigm recognizes that sexual development and sexual difficulties may have multifactorial etiologies related to physical, psychological, and social factors. While physical and psychological factors are acknowledged and identified, the influence of social factors often receive less attention in clinical settings.
Aim This study aims to determine how social, cultural, and religious factors and media influence may influence sexual development, sexual relationships, and sexual function.
Method Review of the most recent literature addressing social and cultural factors related to sexuality was conducted.
Conclusions The impact of culture should be recognized and addressed and clinical recommendations are provided.

Keywords Sociocultural · Culture · Ethnicity · Cultural sensitivity · Sexual dysfunction · Sexual function · Sexuality · Religious beliefs

Introduction

The biopsychosocial paradigm recognizes that sexual difficulties may have multifactorial etiologies related to physical, psychological, and social factors [1]. While physical and psychological factors are acknowledged and identified, and have been extensively researched, the recognition of social factors, which include cultural and religious identification, media influence, and association with sexual and political sub-cultures, has not received the same degree of attention, yet may all influence sexual development, sexual relationships, and sexual function. This chapter will review the most recent literature addressing social and cultural factors related to sexual disorders and will provide clinical recommendations.

Aspects of sexuality that are influenced by culture include values, such as decisions regarding appropriate sexual behaviors, suitable partner or partners, appropriate age of consent, as well as who is to decide what is appropriate. Sociocultural beliefs across the globe influence the answers to each of these questions and in many cases these characteristics are seen as integral to culture. In describing some cases where culture has affected sexuality, specific cultural beliefs should not be used to create stereotypes regarding specific cultures, rather, to gain an appreciation for the affect culture can have on sexuality.

A Changing World

Characterizations of sexuality have traditionally been influenced by both religious and philosophical writings [2]. However, in recent years, altering beliefs and a significant change of attitude have been seen with regards toward same sex marriage (SSM). The legal status of same sex couples was not even placed on the ballot to vote on in the USA only two decades ago [3] while today SSM has been legalized in several countries. Additionally, consensual non-monogamy, swinging, and polyamory appear to have become more prevalent. In the 1970s, there was an estimated 1–2 % of married couples that had at one time been involved in swinging [4]. This

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number has risen to as high as 8 million people currently involved in swinging in the USA [5–7]. Furthermore, Canada has legalized swinger clubs in 2005 [7]. A survey of 375 primarily female undergraduate participants from Poland and the UK found that even with more liberal beliefs toward sexuality, monogamy and polygamy are still seen as more favorable than open and swinging relationships. Unauthorized infidelity was found to be viewed as significantly more negative [8]. It is important to be aware of the changing perceptions toward sexuality even where they may conflict with one's own beliefs.

Acculturation and Immigration

Acculturation or the process of adaptation that occurs when an immigrant raised in one culture arrives in another country with a different culture is another manner by which sociocultural influences can be examined. With more than 3 % of the current worldwide population being immigrants [9, 10], investigation of acculturation has become a very powerful tool in examination of sexuality within cultural minorities and immigrant population.

During the process of acculturation, a family may attempt to retain their patriarchal traditions. This may include the idea of a "virtuous" woman that may clash with the "hypersexualized" media and culture to which they are exposed. Becoming westernized is synonymous with promiscuity in many communities. In some cases, the addition of a new language gives a woman a way to express issues that were taboo in her language of origin [11]. Evaluating the client's level of acculturation may be useful in determining how best to discuss sexuality in context of culture of origin.

Religious Beliefs Affect Sexuality

An additional sociocultural factor that is intricately associated with sexuality is religious beliefs and traditions. Values and traditions regarding sexual meaning, ritual, and practice are essential parts of many religions. Factors such as sexual guilt and shame have been reported in the literature in association with religious influences [12, 13]. However, the degree to which religious beliefs and observance affects sexual function is still unknown [13].

Traditional values that may restrict access to knowledge about sex or stress restricted and limited sexual behaviors may impact sexuality through their influence on emotions including guilt and anxiety [14••]. In the presentation of guilt, shame, or anxiety, discussion of religious beliefs may expose underlying conflicts. A woman's self-worth may be affected by how she perceives herself in others' eyes. She may feel that others are judging her now that she is sexually active. This contributes to how she views herself, and if her self-image is negatively affected, her sexual problems will be perpetuated [15]. Finally, the extent to which normative sexual behaviors may be considered pathological may be governed by religious and cultural beliefs, such that both men and women may report feelings of guilt due to masturbatory habits [16, 17].

Culture Defines Sexuality

Lo and Ko [18] assert that women in Asia rarely consider a lack of sexual desire to be abnormal because Asian women are not entitled to have sexual desire. Additionally, cultural beliefs such as the Hispanic American male's machismo and female's "marianismo" [19•] as well as the Iranian women's maintaining an expected "khanoum-like" image (maintenance of her family's honor) [20•] have been implicated in affecting sexual satisfaction. The concept of *marianismo*, rooted in Catholicism, places the Latino woman in a role of sexual morality, honor, self-sacrifice, passivity, and care-taking while *machismo* defines a male's role of masculinity [19•]. The Hispanic males role of machismo can be temporarily fulfilled by having intercourse but ultimately only pregnancy, either premarital or during marriage, is authentic proof of his machismo or manliness [21].

The idea of gender stereotypes within a culture can be seen with the Hijra of India. Chakraborty [22] describes the Hijra of North India as a world of the "other"; the "other" being women or men who do not fit expected gender norms, such as women who fail to menstruate and transgender males. These individuals are seen as vulgar in their culture and are forced to live in their own isolated communities. The existence of the class defined as Hijra has the potential of causing undo stress to the Indian male, due to fear of possibly being perceived as Hijra, and subsequently being expected to undergo the process of nirvana or rebirth as a women followed by possible castration by a Guru [22].

In an interview with 50 Bangladeshi men, power over women was described as "natural" and "normal." Sexual intercourse, described as a "game" (khela), is the only competition of the sexes, and therefore, this is the only game a man may lose to a woman, a threat to his natural power over the woman [23]. The shame of "losing" or ejaculating before the woman wants to stop threatens the masculine sexuality. Negativity toward premature ejaculation is also seen among Muslims men in the UK, who describe premature ejaculation as a punishment [24].

A clinician can examine underlying cultural beliefs that may cause a client's understanding of normal sexuality or sexual function to deviate from Western definitions which lean more heavily on empirical evidence and research-based concepts. Additionally, they may address sources of anxiety that may be stem from cultural expectations.

Culture Influences the Appropriate Number of Partners Within a Marriage

Cultural influences on decisions regarding the appropriate number of partners have been seen worldwide. The belief that polygamy is legitimate by Shari'ah law is considered normative in Indonesia, especially by Islamist and Salfi groups. The majority of Indonesians do not support this practice [25]. The number of years of education has been shown to impact rates of polygamy among West African Women. Southern Ghana, Southern Nigeria, and Southwestern Kenya all showed higher levels of education as well as lower levels of polygamy [26]. In the setting of polygamy, clinicians should be aware of influences additional parties may have on the client.

Culture Defines Age of Consent

Currently, there are an estimated 700 million women and 156 million men that were married under the age of 18 [27, 28]. Early age marriage was found to be associated with education and economic status in Nepal [29]. Although Islamic/Arabic cultures are portrayed as more repressive to sexual relationships, they approve of sexual intercourse at younger ages if married. Although there is no age restriction to marriage in Saudi Arabia, reaching puberty is generally accepted as marriageable. In some cases, a girl may be married before puberty with the condition that consummation does not take place until after puberty, with the risk of legal action if the husband does consummate the marriage earlier [30]. Maswikwa et al. found that countries that had anti-child marriage laws had 40 % less child marriages as well as 25 % lower teenage pregnancies [31].

The Triangle of Love

The triangular theory of love developed by Sternberg [32] includes three major components: (1) passion, (2) intimacy, and (3) commitment. Generally Western relationships are based on these components. Initially, there is passion and idealization, a development of intimacy and attachment, culminating in commitment and marriage. Traditionally, faith-based cultures may bypass one or more of these phases in cases where the family or community arranges the marriages. Here a couple may only become acquainted, perhaps gain a friendship while gaining no intimacy. This creates a moment where a fundamental shift from complete lack of intimacy to complete sexual intimacy presents. This can lead to a knowledge and communication gap between the partners with regard to sexual expectations [33].

Sexual motives vary from culture to culture. In cultures where sexuality is viewed as an expression of love, devotion, and intimacy, sexual dysfunction may be seen as a threat to the relationship. Where sexuality is viewed as a source of pleasure, disruption of sexual function leads to decrease in quality of life and satisfaction. However, when motivation is reproduction and a marital duty, sexual dysfunction has a completely different meaning and individuals will present with different sexual problems. French men and women associated sexual activity with pleasure (44 %) and love (42.1 %) while rarely with procreation, children, and motherhood (7.8 %) [34]. In Mozambique, women see sexual encounters as pleasurable and successful when the purpose is to become pregnant [35].

Sexual Education—Sexual Imagery

Sexual education has been shown to impact sexual function. When sexual education is lacking, it may be to the detriment of a healthy sexual relationship, such as with unconsummated marriages [36]. Unconsummated marriage is social phenomenon as opposed to a specific sexual dysfunction and refers to a situation whereby a married couple has not engaged in intercourse. As the expectation to have intercourse for the first time on the wedding night exists in traditional and faith-based cultures, as opposed to in modern Western society, the phenomenon is common in traditional populations. While reasons for unconsummated marriage may vary, from a specific sexual dysfunction to psychological and dynamic factors, lack of education about sex, knowledge of genital anatomy, or the physiology of sex are common contributors [36].

Prospective marriages in the Ultra-Orthodox Jewish culture are traditionally set up by a matchmaker. After receiving parental approval, the boy typically meets the girl in a public place to converse. This process lacks physical intimacy and the couple may decide to become engaged after a number of meetings [37]. For many Orthodox Jews, the first sexual education they receive follows engagement. Responses from 380 Orthodox Jewish women, most of whom were virgins on their wedding night, found that 50 % felt insufficiently prepared for married sexual life [38]. Additionally, insufficient knowledge of sexual intercourse has been shown to contribute to development of vaginismus among Arab women [39].

Sexual education may come from many different sources. In Iran and Turkey, sexual information was most commonly gained from friends or the media. In China, a survey of medical students found that 59 % gained sexual knowledge from magazines and booklets, 25 % from radio and movies, 12 % through school, and 3–4 % from parents [40]. A small survey of low income Black, Hispanic, and Multiracial 17–18-year olds in the USA found that 78 % of males and 50 % of females had viewed pornography more than 10 times in the past

year while 11 % of males viewed pornography many times a day. Pornography viewing was described as a method of enhancing sexual education for both genders [41•].

Ybarra [42] describes sexual media as virtually impossible for youth to avoid. Exposure to sexual material was found to relate with having sex and coercive sex. An increase in sexual violence victimization was also observed. Interestingly, Ybarra [42] found that longer standing forms of media such as TV and movies as opposed to Internet affected sexual behavior outcomes [42] Pizzol et al. found that among 1565 students 77.9 % of whom viewed pornography, 10 % reported reduced sexual interest toward potential real-life partners and 9.1 % described an addiction to pornography [43]. In addition to teenagers actively viewing sexual imagery, in 2008 it was revealed that 20 % of US teenagers sexted, taking an active role in disseminating sexually explicit images via mobile phone and the internet [44, 45].

Cultural Impact on Sexual Dysfunction

In addition to influencing sexuality, culture has also been shown to affect the presentation of sexual dysfunction. The 5th edition of the Diagnostic and Statistical Manual of Mental disorders (DSM-5) includes four male and three female sexual disorders. Male sexual disorders include the following: (1) delayed ejaculation, (2) erectile disorder, (3) premature (early) ejaculation, and (4) male hypoactive desire disorder. The female sexual disorders include the following: (1) sexual interest/arousal disorder, (2) genito-pelvic pain/penetration disorder, and (3) female orgasmic disorder. In addition, a new group of associated features includes among others: cultural or religious factors (e.g., inhibitions related to prohibitions against sexual activity or pleasure; attitudes toward sexuality), which orient the clinician to assess for the impact of culture and religious factors on the individual's sexual functioning [46, 47].

While sexual dysfunction is seen worldwide, the presenting symptoms as well as expectations in treatment may vary. Western-defined dysfunction may present with a culturally appropriate explanation and treatment such as was the case in areas of rural Iran where patients with unconsummated marriages believed that they were "locked" and required to be "opened" by a traditional healer [48]. Yasan et al. [49] explains how a newlywed suffering from vaginismus—involuntary contraction of the pelvic floor muscle group leading to painful and/or impossible vaginal penetration—has an enormous social pressure to consummate the marriage on the first night of marriage or soon thereafter. An unconsummated marriage could expose these women to a loss of social status and additional trauma.

Cultural beliefs do not always correlate with the practitioner's views. For example, practice of "dry sex" observed in Sub-Saharan Africa as well as Asia and Latin America is described as a voluntary modification of the vagina to create a virgin like state, to represent a woman's youthfulness as well as create more friction for more enjoyable intercourse. This practice correlates with the Zulu of South-Africa tradition describing copious lubrication to be seen as a product of disease or infidelity [35, 50–52]. Western clinicians are more prone to see vaginal dryness presented as a dysfunction such as with a lack of sexual arousal [53, 54].

While sexual dysfunction such as unconsummated marriages may present within both Western and non-western cultures, there are sexual dysfunctions that may present as distinct dysfunctions practically unseen anywhere else in the world.

Kumar et al. [55] describes an outbreak of Koro affecting thousands of people that took place in India in 2010. Patients, typically young unmarried males, presented with "(1) tingling sensation that starts from the thigh and goes to the abdomen or other parts of the body. (2) Shortening of the penis. (3) Severe degrees of anxiety with increased worrying about his genitalia, restlessness, help seeking behavior, increased sweating and a fear of death" [55]. Although recently Koro has presented with sociocultural origin, the "physiological disappearance of the penis" is termed by some authors as a universal syndrome due to it having been described in Europe during medieval times in Europe [56, 57].

Cultural influences may be seen with regards to delayed treatment of sexual dysfunction among Muslim women due to ideals of modesty, as well as preference of same gender therapist [58••]. Ribner [59] explains that it may be critical to incorporate religion into the therapy and, in some cases, even involve clergy. It is important to explore these expectations and avoid misrepresentation in the development of culturally appropriate care. Failure to address cultural dissonance may lead to patients failing to return for follow-up appointments, leaving them as an underserved population [60].

Interview in a Culturally Appropriate Way

Sexual health assessments should include a cultural intake and follow guidelines such as the recommendations from the 4th International Consultation on Sexual Medicine presented in Table 1 [61].

Evaluation of the importance and effects of culture requires cross-cultural scales that currently do not reflect cultural diversity very well [62]. Lacking these cross-cultural scales, clinicians must use verbal interviews to gain a sensitivity of the patients' culture [63]. Broad

Table 1 Recommendations of the 4th International Consultation on Sexual Medicine

Recommendation	LOE/Grade
Evaluate patients and their partners in the context of culture.	4/Grade C
Evaluate distressing sexual symptoms regardless of whether they are a recognized dysfunction.	4/Grade C
Conduct a culturally sensitive interview that acknowledges cultural factors and language barriers and includes agreement on what language and style would feel most comfortable for the client or couple.	4/Grade C
Assess heterosexual couples presenting with unconsummated marriage for the presence of female (vaginismus) or male sexual difficulties (e.g., premature ejaculation) and impact on each other.	4/Grade C
Develop culturally and religiously sensitive assessment skills.	4/Grade C
Suspend preconceptions about clients' race/ethnicity/gender/sexuality and that of their family members.	4/Grade C

direction has been advised to include four points [64]: (1) awareness of differences, (2) knowledge of the client's culture, (3) distinguishing between pathology and culture, (4) use of a culturally appropriate therapy.

When conducting a sexual health interview, the interviewer must cultivate an environment in which the client's sociocultural and religious values can be properly examined with awareness and sensitivity. The fear of appearing to be uninformed or ignorant of another's cultural norms leads to hesitancy in approaching sensitive topics. Political correctness, especially regarding the immigrant and minority populations within Western countries, is a source of hesitation in addressing aspects of the client's sexuality that may be important for treatment. While clinicians must make a conscious effort to increase their knowledge and awareness of their patients' culture, an open conversation is most effective in examining the patient's personal cultural values. Hanson et al. [65] has found that of 149 psychologists studied, 27 % rarely or never referred their clients to a therapist more culturally appropriate. Additional resources should be reviewed to expand the clinician's sensitivity [14••, 62, 66••]. Acculturation should be included in discussions regarding client's culture, an area which culture-centered research is currently lacking clear consensus. Assumptions of a client's cultural values due to appearances will inhibit proper evaluation of client specific goals and expectations.

Sensitivity to a culture does not indicate agreement with the client's beliefs rather it is a method by which to accept that there are differences in values. Introspection of one's own feelings and beliefs is needed to allow for the client's needs to be addressed without influence from the clinician's preconceptions. This includes acknowledgement of one's own limitations in providing proper care.

While a client may not expect all clinicians to understand all values and practices of all cultures, the client does expect a sensitive atmosphere in which to discuss them. Generally, the client is happy to discuss the values, rituals, and practices of their culture.

A clinician should be aware of issues that may present in the treatment of religious clients. These include restrictions against premarital sex, as well as certain sexual practices even after marriage. These may include restrictions on masturbation, condom use, sexual positions, and extra-vaginal ejaculation. Always ask the clients directly regarding their personal practices, as assumptions may prove to be incorrect. Use the couples input to create and modify the treatment plan as needed [12, 14••, 67]. Additionally, the couple may want to consult their religious leaders during the course of planning and treatment for input.

Conclusions

The impact of culture must be addressed when approaching sexuality. Clinicians should be aware and attempt to gain an understanding of the different cultural beliefs with which their clients may present. These principles affect all aspects of sexuality including beliefs regarding an appropriate partner or partners, appropriate age of marriage, appropriate sexual behaviors as well as how they should be approached by the clinician. Cultural sensitivity and awareness is an important aspect of any clinician-client relationship and must be used to develop a culturally appropriate treatment for the client. While social factors and culture contribute to sexuality, its effect in relation to acculturation is still unknown, making the interview an important part of learning about the client's cultural influences that must be addressed.

Compliance with Ethical Standards

Conflict of Interest JH, SA, and TR declare that they have no conflicts of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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